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AUDITOR GENERAL
MANITOBA

December 2008

Report to the Legislative Assembly - Audits of Government Operations

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December 2008

The Honourable George Hickes
Speaker of the House
Room 244, Legislative Building
Winnipeg, Manitoba
R3C 0V8

Dear Sir:

I have the honour to transmit herewith my *Report to the Legislative Assembly - Audits of Government Operations* to be laid before Members of the Legislative Assembly in accordance with the provisions of Sections 14(4) and 28(1) of The Auditor General Act.

Respectfully submitted,

Carol Bellringer

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Overview by the Auditor General

I am pleased to present my 2008 report to the Legislative Assembly on government operations. This report combines the results of four audits and introduces a new form of reporting by my Office.

It is my intention to combine audit reports in this manner for distribution to Members of the Legislative Assembly at least once each year. In addition to this new combined annual report on government operations, I will continue to report annually on our audit of the Public Accounts (to be issued in December for 2008) and on our Office operations (issued in July of each year). As required by my Act, Special Reports will continue to be made to the Assembly on any matter of pressing importance or urgency that should not be deferred until the next annual report.

Each of the four audits is reported in a "Chapter" and all four audits were conducted in accordance with value-for-money auditing standards recommended by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

All four audits in this report contained positive conclusions, yet each one identifies areas where attention is required to strengthen operations and where matters of non-compliance should be rectified. The audits are summarized below. Each of the chapters which follow provides further information about the program, our audit objectives, findings and audit recommendations. We also give departmental management the opportunity to respond to our reports and we include their comments. In all cases, we had the full cooperation of departmental staff as well as individuals working in the pharmacies visited (Chapter 3). We would like to thank each of them for their time and assistance throughout our audits.

Chapter 1: Employment and Income Assistance (EIA) Program

The EIA Program provides funding for the basic needs of individuals and families who have exhausted other means of financial support, as well as a variety of other supports to assist individuals in entering, re-entering or remaining in the work force. We examined the Department of Family Services and Housing's processes for ensuring that only eligible applicants receive income assistance and that eligible individuals are paid the correct amounts. We also examined employment enhancement referral and monitoring processes and the income assistance rate setting process.

Our audit concluded that the Department adequately assessed eligibility in accordance with *The Employment Income Assistance Act* and regulation, that benefit payments were accurately calculated in accordance with prescribed rates in most cases and that the Department had dedicated investigative staff in place.

Our recommendations focused on the need to strengthen the processes around the verification of information provided by applicants and file documentation including documented rationale for certain decisions. We also identified opportunities to better detect potential overpayments and recommended that a formal documented process be put in place to review and determine income assistance rates.

Chapter 2: Monitoring Compliance With The Ambulance Services Act

Ambulance Services provides emergency medical response and transportation services, by ground ambulance or air, for individuals in need. We examined the Department of Health and Healthy Living's processes for administering the provisions of *The Ambulance Services Act* and *Ambulance Services and Licenses Regulation* as they related to licensing, inspection and the minimum specifications for equipment.

We found that the Department was appropriately administering the provisions of the Act and regulation as they related to licensing, inspection and the minimum specifications for equipment, except that there was a need to ensure that ambulance service providers that held a provisional license were complying with the provisions of their license; to ensure that ambulance attendants that held a probationary license were complying with the restrictions of their license; to license aeromedical pilots and aeromedical attendants; to verify that all applicants for ambulance attendant licenses were at least 18 years old and that applicants for ambulance operator licenses held at least a class 4 driver's license. The Department has indicated to us that all of our recommendations have now been addressed.

Chapter 3: Pharmacare Program - Part 2

The objective of Pharmacare is to fund pharmaceutical benefits as provided for in *The Prescription Drugs Cost Assistance Act* and related regulations, protecting residents of Manitoba from financial hardship resulting from having to cover expenses for prescription drugs. Our audit objectives were to determine whether the Department of Health and Healthy Living had adequate processes in place around eligibility, the accurate calculation of the insured person's deductible, to ensure pharmacy compliance with Acts and regulations, to ensure that only accurate and valid claims are paid and whether the pharmacies are complying with the procedures and guidelines related to making accurate and valid claims.

Our audit concluded that appropriate processes were in place in most areas and that pharmacies were complying with the procedures and guidelines related to making accurate and valid claims. We found opportunities to improve the communication process around eligibility, processes around changes to the person's third party insurance status, monitoring of professional fees claimed

and the effectiveness of the investigation and audit functions. We also reported that the Pharmacare program was not in compliance with the requirements of the Act and regulations in regard to accounting for the recovery of drug costs by Pharmacare beneficiaries from third party insurance providers, resulting in potential Pharmacare overpayments.

Chapter 4: Compliance With Oil and Gas Legislation

The purpose of our audit was to evaluate the efforts of the Department of Science, Technology, Energy and Mines to ensure compliance with *The Oil and Gas Act* and related regulations in managing Manitoba's oil and gas resources. The Department manages these resources through the administration of several Acts and regulations.

We found that the Department was appropriately administering the provisions of the Act and related regulations as they related to permits and licenses. We determined that the appropriate amount of taxes and royalties were being assessed and paid on oil and gas production in Manitoba with one exception. In that situation, royalties and taxes were not determined in accordance with the regulation resulting in an under-payment of the royalties and taxes otherwise payable. We also identified the need to improve follow-up procedures where information on royalties and taxes was not being submitted on time; to recalculate taxes and royalties payable on a more timely basis; and to verify submitted information.

Family Services and Housing

Chapter 1: Employment and Income Assistance Program

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1.0 Main Points

What We Examined

The Department of Family Services and Housing is responsible for administering the Employment and Income Assistance (EIA) Program. The EIA Program provides funding for the basic needs of individuals and families who have exhausted other means of financial support, as well as a variety of other supports to assist individuals in entering, re-entering or remaining in the work force. We examined the Department's processes for ensuring that only eligible applicants receive income assistance and that eligible individuals are paid the correct amounts. We also examined employment enhancement referral and monitoring processes and the income assistance rate setting process.

Why It's Important

The EIA Program has significant social and economic impacts. In 2007/08, the Program provided approximately $278 million to over 56,000 Manitobans in need of assistance.

What We Found

- The Department assessed eligibility in accordance with the EIA Act and Regulation. However, we found that the Department did not regularly select a sample of EIA files to verify in greater detail the financial and other information obtained from applicants in order to ensure initial and on-going eligibility. Verification of this nature was only done in those circumstances where the information obtained appeared questionable. For example, requesting information from the Canada Revenue Agency in order to assess on-going eligibility was relatively rare. In addition, home visits to verify on-going eligibility were not always conducted every two years as required by departmental policy and the rationale for waiving these home visits was not always properly documented.
- In some cases, file documentation concerning proof of identify was incomplete.
- In most cases, an EIA Assessment Panel (Medical Panel) provided recommendations concerning eligibility for the persons with disabilities category. However, some decisions concerning eligibility for the persons with disabilities category were being made without first seeking recommendations from a Medical Panel, which may lead to inconsistent decision-making.
- Required annual review forms, monthly income declarations, and job search activity reports were generally being received from applicants and reviewed

by EIA Program staff. However, if annual review forms were not received, we found that follow-up actions, and the rationale for those actions, were not always documented.

- The Department had dedicated Investigations staff to follow up concerns with respect to potential program abuse.
- There were several agreements in place with a variety of jurisdictions and agencies that enabled regular information sharing in order to detect potential overpayments; however, there is room for further expansion in this area.
- Overpayments on open EIA cases were recovered through deductions from on-going benefits. Overpayments on closed cases were primarily managed through an agreement between the Department and the Canada Revenue Agency which allows the Agency to send applicable tax refunds (e.g., GST refunds) directly to the Department to be applied to outstanding overpayments, as well as through individual garnishee orders and voluntary payment arrangements.
- Benefit payments were accurately calculated in accordance with prescribed rates in most cases, although a small number of errors related to the accuracy and/or timeliness of data entry were noted.
- File documentation concerning participant work history and educational background, participant action plans, the authorization and rationale for training referral decisions, and attendance and progress in training programs was sometimes incomplete.
- The Department reviewed income assistance rates on an annual basis and the rates, as well as income and asset exemption levels, were periodically adjusted. The review considered several different factors: inter-provincial comparisons of the basic and shelter rate amounts, other benefits available to EIA participants, and various available low income threshold measures. However, there was no structured or documented process to ensure rates were determined in an equitable and defensible manner.

2.0 Audit Approach

2.1 Audit Objectives

We identified four objectives for our audit of the EIA Program:

1. To determine whether adequate processes were in place to ensure only eligible applicants were approved to receive income assistance **(Section 4.0)**.
2. To determine whether adequate processes were in place to ensure eligible individuals were awarded and paid only the amounts to which they were entitled **(Section 5.0)**.
3. To determine whether adequate referral and monitoring processes were in place to ensure EIA Program participants had timely access to needed employment enhancement activities and participated as expected **(Section 6.0)**.
4. To determine whether the rate setting process adequately supported the Program's objectives **(Section 7.0)**.

2.2 Audit Scope

The audit was conducted between September 2007 and May 2008. It included review and analysis of a sample of Program participant files, applicable legislation, policies and procedures, and information stored in the Social Assistance Management Information Network (SAMIN), as well as discussions and interviews with Department directors, supervisors, analysts, investigators and caseworkers.

The participant files examined were chosen from a selection of Winnipeg, rural and northern offices. These offices were selected based upon consideration of the total office caseload, caseload per worker, cost per case, and discussion with Department staff.

Our audit did not extend to the Health Services and Building Independence Programs or to the appeal process administered by the Social Services Appeal Board. In addition, while our audit examined the rate-setting process, we did not examine the adequacy of rates relative to participant needs.

3.0 Background

The Employment and Income Assistance (EIA) Program is a social safety net of last resort designed to meet the basic needs of individuals and families that have exhausted other means of financial support. The Program has a significant social and financial impact, providing approximately $278 million to over 56,000 Manitobans in need of assistance in 2007/08. In addition, the Program provides employability assessments, personal job planning, work incentives and other supports to assist Manitobans in entering, re-entering or remaining in the labour force.

The Program is administered by the Department of Family Services and Housing and operates under the authority of *The Employment and Income Assistance Act* and *The Employment and Income Assistance Regulation.* Eligibility for income assistance is determined by a needs test, which compares the total financial resources of a household to the total cost of its basic necessities as defined in the Act and Regulation.

The Department's Annual Report states that the major objectives of the EIA Program are:

> *"To assist Manitobans in regaining their financial independence by helping them to make the transition from income assistance to work; and*
>
> *To provide income assistance to Manitobans in need".*

The EIA Program is delivered by approximately 445 full time equivalent positions through a network of 25 Community Services Delivery offices, located in Winnipeg and throughout rural and northern Manitoba.

EIA also administers the Health Services Program and programs under Building Independence. The Health Services Program provides drugs, dental and optical services to EIA participants and children in care. Building Independence supports partnerships promoting job opportunities for EIA participants.

The average monthly total of EIA cases in Manitoba has been gradually decreasing over the last three years. **Figure 1** shows the total number of EIA cases and related household participants between 2005/06 and 2007/08, by recipient category.

Figure 1

Recipient Category	2005/06		2006/07		2007/08	
	Cases	Participants	Cases	Participants	Cases	Participants
Children	58	80	54	82	45	73
Single parents	9,024	27,496	8,555	26,317	8,189	25,409
Aged	110	160	101	143	100	145
Crisis Facility cases	52	118	47	110	47	107
General assistance	5,582	10,046	5,087	9,116	4,641	8,475
Special cases	27	33	12	16	6	17
Persons with disabilities	17,553	22,102	17,783	22,494	17,915	22,543
Total	**32,406**	**60,035**	**31,639**	**58,278**	**30,943**	**56,769**

Source: Department of Family Services and Housing

Total expenditures for the EIA Program have also decreased over the last three years. **Figure 2** shows program expenditures between 2005/06 and 2007/08, by recipient category. During this time period, total program expenditures decreased 1.6%, while the total number of EIA cases decreased 4.5% and the total number of participants decreased 5.4%. This reflects changes in the caseload mix and income assistance rates. Over this period, the number of cases and participants in the single parent and general assistance categories has steadily declined and, accordingly, expenditures for the single parent and general assistance caseloads decreased 6.4% and 10.9% respectively. In contrast, expenditures for the persons with disabilities caseload increased by 4.3%, reflecting the 2.1% increase in the number of cases.

Figure 2

Employment and Income Assistance Expenditure by Category			
Recipient Category	**2005/06**	**2006/07**	**2007/08**
Children	$ 242,300	$ 236,900	$ 199,400
Single parents	101,660,700	97,484,900	95,160,300
Aged	641,400	645,500	745,300
Crisis Facility cases	411,900	336,800	388,500
General assistance	37,432,400	34,329,800	33,341,800
Special cases	1,050,400	1,760,000	1,763,000
Persons with disabilities	139,438,400	140,847,400	145,400,500
Other	1,589,900	524,400	994,300
Total	**$282,467,400**	**$276,165,700**	**$277,993,100**

Source: Department of Family Services and Housing

4.0 Eligibility

Eligibility for the EIA Program is governed by *The Employment and Income Assistance Act* and the *Employment and Income Assistance Regulation.* An individual must be both "financially" and "categorically" eligible to receive income assistance. Financial eligibility is assessed by determining if the cost of an applicant's basic necessities exceeds their financial resources. Categorical eligibility refers to those categories of persons, as defined in the EIA Act, to whom assistance may be payable.

Due diligence with respect to eligibility is important to ensure participants receive the appropriate level of benefits to which they are entitled. Personal and financial circumstances of EIA participants may change over time. Consequently, eligibility needs to be assessed when individuals first apply for income assistance, as well as on an on-going basis.

4.1 Assessing Initial Financial Eligibility

As set out in the EIA Act and Regulation, financial eligibility is assessed by determining if the cost of an applicant's basic necessities exceeds their financial resources.

Basic Necessities: Refers to those items and services that are essential to the health and well-being of a participant, including a basic living allowance (such as food, clothing, personal needs and household supplies), an allowance for shelter, and essential health services. These form an applicant's "basic needs" when developing a monthly budget.

Financial Resources: Refers to the following:

- All the real and personal property of an applicant, including the net income from any such property;
- Allowances, pensions, insurance benefits and income from business, farming or any other source received by an applicant;
- Gifts and gratuities whether in cash or in kind received by an applicant on a one time basis or otherwise; and
- The values attributed to free shelter received and/or free board or lodging received by the applicant.

There are certain types of assets and earnings that are excluded from the calculation of financial resources, such as the Canada Child Tax Benefit and the Federal Universal Child Care Benefit. In order to provide an incentive for EIA participants to return to the workforce, the EIA Program also allows a portion

of employment income to be excluded from the calculation of an applicant's financial resources.

Observations and Conclusions

4.1.1 Financial eligibility guidelines were publicly available and clearly communicated

- Information about the financial eligibility guidelines of the EIA Program was readily available through the Department's website. Information was also easily available through brochures and other material available at all Community Services Delivery offices. In addition, Department staff held regular information sessions that provided financial eligibility information.

4.1.2 Financial information was obtained from applicants and verified in accordance with the EIA Act and Regulation, but a further examination of an applicant's financial situation, including a search for non-disclosed assets only occurred in circumstances where the information appeared questionable

- We found that for all files we examined, caseworkers appropriately assessed financial eligibility in accordance with the EIA Act and Regulation based upon the information provided by applicants.
- We found that the EIA Program application forms required applicants to provide detailed information about both their financial needs and their financial resources, including the assets, debts and income of all household members. The forms included a declaration regarding the accuracy and completeness of the information provided, signed by the applicants. All of the applications we examined were signed.
- The specific financial needs information provided on the forms typically consisted of shelter and utilities costs, as most other financial needs were allowed for through the standard basic necessities allowance. Information was also provided concerning liquid assets, such as all bank accounts and investments, as well as other assets, such as real property and vehicles. This information was then used by the Program to determine whether the applicant's financial resources were less than their needs, making them financially eligible for EIA program benefits.
- As part of the application process, applicants were required to provide copies of statements for all their financial institution accounts. The application also required the applicant to sign an authorization which would allow the Program to obtain the applicant's income tax returns. Tax returns were not obtained routinely since this was not a requirement and, while they may be requested by caseworkers for further verification

of financial information, we did not observe any examples of this in our selected sample.

- The Department obtained financial information from applicants for all of our sample items and verified the information provided. However, they did not perform additional work to determine if the information provided accurately represented the applicant's financial situation. This may result in applicants being incorrectly declared financially eligible for EIA benefits. For example, a single bank account statement does not provide sufficient proof of financial eligibility as an applicant may have more than one bank account or accounts with different financial institutions for which statements may not be provided. Similarly, self disclosure of real and personal property does not provide proof of financial eligibility as an applicant may not declare all property.
- The Department informed us that if information appears questionable during the intake process, the case is forwarded to the Department's investigation staff for follow-up. The work of investigation staff is discussed further in **Section 4.4**.

We recommend that the Department develop procedures to further verify the financial information provided by applicants. This could include, for example, conducting credit checks on a test basis, requesting certain tax information from the Canada Revenue Agency, and/or selected home visits to verify assets.

4.1.3 Financial eligibility decisions and information on the appeal process were clearly explained and communicated to applicants

- Decisions made by the Program as to whether an applicant was eligible for benefits or not were communicated to applicants through a letter that was generated by SAMIN. The letters included detailed information about eligibility and also provided information on the appeal process available to the applicant, along with the address of the Social Services Appeal Board.

4.1.4 Regular detailed file reviews were not being conducted and/or documented by supervisors

- The EIA Administrative Manual requires that each EIA office director or designate review 10% of new or re-opened files each month. This file review would assist the Program in ensuring that applicants are financially eligible, as well as placed in the correct category. However, the Manual does not indicate the specifics of the required review and the Department has not developed a standard template or process for this review.

- At the Community Services Delivery offices that we attended, we found that only one office had a regular file review process in place to ensure that at least ten percent of new or re-opened files were reviewed by a director. In the other offices, reviews were either not completed or evidence of file reviews could not be provided. This may result in errors and/or irregularities not being detected in a timely manner.

We recommend that the Department re-emphasize the importance of file reviews to supervisors in all offices and develop specific procedures and documentation standards to ensure that 10% of all new or re-opened files are reviewed each month, as required by the EIA Administrative Manual.

4.2 Assessing Initial Categorical Eligibility

Categorical eligibility refers to those categories of persons, as defined in the EIA Act, to whom assistance may be payable. These categories are outlined both in the EIA Act and in the EIA Administrative Manual.

Categorical eligibility is a key element in establishing the allowance that program participants will receive. The EIA Administrative Manual contains three different monthly basic allowance rate tables depending on the enrolment category.

The following three categories of eligibility comprise the majority of the recipients of assistance:

1. ***Persons with Disabilities***: Refers to applicants suffering from physical or mental ill health, incapacity or disorder likely to last longer than three months. Applicants must submit an examination and report form completed by their medical practitioner for review by the Director. This report may also be forwarded to the Department's EIA Assessment Panel (Medical Panel).
2. ***Single Parents***: Refers to applicants who have physical custody of a dependent child or children for whom the applicant is the sole legal guardian at least 50% of the time.
3. ***General Assistance***: A category for applicants that do not fall within any other category. Generally, this category is for non-disabled adults who are expected to seek employment.

The sample of files that we selected during our audit was drawn exclusively from these three categories.

Observations and Conclusions

4.2.1 Needs categories were clearly defined

- We found that the different need categories outlined in the EIA Administrative Manual were clearly defined, comprehensive and included all need categories outlined in the EIA Act. Documentation explaining the need categories was also readily available on the Department's website and from Community Services Delivery offices.

4.2.2 Application forms were properly completed and information properly input into SAMIN

- We found that the standard application forms used by the Program requested the applicant to provide all of the information required by the EIA Administrative Manual to determine categorical eligibility, such as the identity of all household members.
- For the sample of files that we reviewed, we found that only 2% of the files did not contain an application form. In these instances, SAMIN contained all of the participant's required information, which we were able to verify as correct through other documentation present in the case file. For all other files selected, there was a properly completed application form. We also found that, in all of the files reviewed, relevant information had been properly input into SAMIN.

4.2.3 Evidence of participant proof of identity was insufficient

- Applicants were required to provide appropriate identification with the completed application. The EIA Manual, Section 6.4.10, states that each applicant *"must provide at least two identification documents on his/her own behalf and at least one for each remaining family unit member for whom assistance is being requested. Verification that the identification documents have been reviewed, or that copies have been placed in a participant's file, is required for each member of the applicant's household".*
- The Manual lists the following as acceptable pieces of identification:
  - birth certificate;
  - social insurance card;
  - driver's license (Manitoba or other jurisdiction);
  - passport;
  - immigration documents (such as Record of Landing, Acknowledgment of Convention Refugee Claim, Minister's Permit, Employment Authorization);
  - Commemoration or Certificate of Canadian Citizenship;

  - Treaty Indian card;
  - Liquor Control Commission photo ID card;
  - other photo ID card; and
  - a letter from a responsible community member familiar with the applicant, describing them and vouching for their identity.

- Evidence that sufficient identification had been obtained from applicants was not available in 26% of the files we selected. Of these files, 58% were from rural Community Services Delivery offices and 42% were from Winnipeg offices.

- We found that rural cases presented a unique situation for caseworkers. Many rural applicants live in remote areas and caseworkers often travel to the applicant's residence to conduct an intake session and complete the application. In these instances, no photocopier is available to photocopy the identification presented, and so it is considered acceptable for a caseworker to view the applicant's identification and then later record in SAMIN that the identification was viewed. However, the files that did not have evidence of sufficient identification did not have either a photocopy of the identification or documentation that the identification had been viewed.

- We found that the Winnipeg files where we did not find sufficient identification were primarily older files that had been active for many years or files where only one appropriate piece of identification had been obtained. These older files, some dating as far back as the 1960s, did not consistently contain copies of identification as this was before the prevalence of photocopiers. It was also before the use of SAMIN and, accordingly, we expected the paper case file, as opposed to SAMIN, to have an indication that the identification had been viewed. We also expected that copies of appropriate identification would have been obtained in later years as enrolment identification is to be updated as necessary on an ongoing basis. However, we did not find this to be the case.

We recommend that the Department obtain copies of two pieces of identification as proof of identity from all applicants seeking or currently receiving assistance. In cases where it is impossible to obtain copies of proof of identity documents, the Department should ensure that identification documents are viewed by the caseworker and that this is documented in the case file.

4.2.4 Documentation supporting categorical eligibility was generally sufficient

- The documentation supporting an applicant's benefit category is important since inappropriate or incomplete documentation may result in placement in an incorrect category and potential over-payment or underpayment, depending on the circumstances.
- For the sample of files that we reviewed, we found that only 1% of the files did not contain sufficient evidence to support the category in which the recipient was placed. In two cases, the date entered into SAMIN as the date the eligibility for the disability category was to expire was later than the date indicated on the medical assessment form. In one other case, there was no medical assessment form found in the file, nor any alternative supporting documentation.

4.2.5 Medical Panels were used inconsistently

- Applicants in the persons with disabilities category were required to have a medical assessment form completed by their medical practitioner, which, in most cases, was then reviewed by a departmental EIA Assessment Panel (Medical Panel). There are six Medical Panels, one in Winnipeg and five serving the rural and northern EIA offices. The EIA Administrative Manual states each Panel is to be comprised of the EIA director or designate and the regional Medical Officer of Health (or private physician if that person is unable to serve). The precise makeup of the Panels varies. For example, the Department reported that the Winnipeg Panel had a nurse and an occupational therapist, while most rural Panels had medical doctors.
- The Panel members complete and sign the appropriate section of the medical assessment form as evidence of their review. If the Panel deems the applicant eligible for the persons with disabilities category, they indicate the date until which the applicant is eligible. The review constitutes a recommendation to the EIA office director, who makes the final determination. The medical assessment form is retained in the applicant's EIA file.
- We were informed by the Department that use of the Medical Panels was not required and therefore not all offices were referring medical assessment forms to the Medical Panels. Some office directors performed the review and duties associated with the Panel on their own, without input from the Panels. This increases the likelihood of inconsistent decision-making in similar circumstances, both with respect to medical disability eligibility and the related eligibility time period to be allowed without receipt of updated medical information. Based upon our interpretation of the EIA Administrative Manual, all initial

medical assessment forms should be referred to a Medical Panel for a recommendation.

We recommend that all decisions concerning eligibility for the persons with disabilities category be made using a consistent process. This could be accomplished by having all medical assessment forms reviewed by a Medical Panel.

4.3 Assessing Ongoing Eligibility

The personal and financial situations of EIA participants can change significantly over a period of time. Applicants meeting both categorical and financial eligibility guidelines initially may no longer be eligible in the future. Therefore, the Department has instituted several processes to assist caseworkers in assessing ongoing eligibility, such as annual reviews, income declaration statements, and home visits.

Observations and Conclusions

4.3.1 Annual review forms were received from EIA participants and reviewed by caseworkers for the majority of files reviewed

- The EIA Administrative Manual states that *"each participant's eligibility must be reviewed at least annually and assistance adjusted accordingly"*.
- Each year, an annual review form is automatically generated by SAMIN and mailed to each EIA participant. The form asks EIA participants to provide updated information about all of the members of their household, as well as current financial information. In cases where the Program pays utility costs, this includes a requirement to forward all utility bills for the past 12 months so that the Department can reconcile the utility amounts paid to participants to the actual cost of utilities. The form also contains a declaration which must be signed by the participant indicating their ongoing legal obligation to keep the Department informed of any changes in their financial or family situation.
- Caseworkers review the annual review forms when they are received to ensure they are completed appropriately and the caseworker updates the information in SAMIN.
- In 4% of the files that we reviewed, we did not find an annual review form for at least one of the most recent three years (2005, 2006 and 2007). However, in these cases, it was indicated in SAMIN that the forms were reviewed by the caseworkers. The Department should ensure that these forms are received from all participants. In some cases, the only contact

the Program has with participants is through the annual review form. The discussions that we had with caseworkers indicated that missing annual review forms were most likely a result of misfiling or a filing backlog.

4.3.2 Follow-up actions for failing to complete and return annual review forms were not always taken and/or properly documented

- When participants fail to complete and return an annual review form, caseworkers may maintain, suspend, or cancel benefits, depending on the circumstances and the category of the recipient.
- In addition to our base sample, we reviewed a limited number of files specifically where annual review forms were not returned in order to assess whether appropriate follow-up actions were taken and properly documented in the files. We found that 31% of these files did not have any documentation concerning follow-up actions and the rationale for those actions.

We recommend that the Department ensure the consistent documentation of follow-up actions, including the rationale for those actions, in those circumstances where annual review forms have not been completed and returned by participants in a timely manner.

4.3.3 Where required, monthly income declarations and job search activity reports were received from EIA participants and reviewed by caseworkers

- The EIA Administrative Manual states that all EIA participants with earnings are responsible for making a full declaration of income and expenses at the end of each month. The Income Declaration form requires EIA participants to enter various types of income, as well as any expenses related to their declared income. Supporting documentation, such as pay stubs, must also be submitted.
- EIA participants who are not currently employed, but have employment expectations, (primarily General Assistance participants) may be required to complete a Job Search Activity Report and return it to their caseworker monthly. This report is automatically generated by SAMIN and requires participants to list the jobs they have applied for during the month and the outcome of these applications in sufficient detail so as to allow Program staff to follow-up with the contacts listed. Generally, participants are required to make 15 job related contacts each month, although this number will be reduced in geographic locations where employment opportunities are limited.
- Our audit found that caseworkers were conscientious with respect to ensuring that income declarations and Job Search Activity Reports were

received each month where required. In all cases we reviewed where these documents were not submitted in a timely manner, the appropriate sanctions were applied and documented in the file.

4.3.4 Home visits were not always conducted every two years as required by EIA policy and the rationale for waiving home visits was not always documented

- The EIA Administrative Manual states that home visits are an *"important form of participant contact. Home visits allow the worker to focus significant attention on participants and have four objectives:*

    1. *to promote the participant's self-sufficiency;*
    2. *to exchange information;*
    3. *to determine other agency involvement; and*
    4. *to examine verification/control issues".*

- The Program's current policy with respect to home visits is that they should be done at least once every two years. However, caseworkers have the discretion to waive home visits that they deem unnecessary. If a home visit is waived, the reason must be documented in SAMIN.
- We found that 15% of the files we reviewed did not have a home visit conducted during the preceding two-year period. These files also did not have a home visit exemption code entered into SAMIN. A home visit exemption code indicates the reason that a home visit has been waived for that particular participant.
- We also found that in 5% of the files we reviewed, codes were entered into SAMIN to indicate that the home visit would be waived; however, there was no documentation as to why the home visit was waived. The EIA Administrative Manual indicates that in cases where the caseworker determines that a home visit is not necessary, the rationale should be documented on the Case Management Intake Record or the Case Management Record.
- In cases where a home visit is not conducted and there is no appropriate justification, the Department cannot be sure that it is meeting the four objectives of home visits listed above.

We recommend that the Department ensure that home visits are performed on all EIA files at least once every two years, as required by the EIA Administrative Manual. Where the Department feels that a home visit is not warranted, a documented reason should be provided.

4.4 Investigations

The Department has dedicated Investigations staff. The goal of EIA Investigations staff is the prevention and early detection of misuse of the EIA program.

Observations and Conclusions

4.4.1 There was a formal process in place to follow-up on concerns about potential misuse of the EIA program

- Investigators undertake two basic types of investigations: intake investigations and general investigations. Intake investigations support caseworkers making initial enrollment decisions who have noticed unusual or suspicious circumstances that require further exploration. General investigations are initiated in response to third party allegations received through the departmental general information line, information exchanges with other provinces or agencies, and/or file reviews and home visits conducted by program staff.
- While the majority of investigations undertaken are related to the potential misuse of the program by EIA participants, investigators may also periodically support investigations of EIA suppliers, such as landlords, medical providers and transportation companies.
- At the time of our audit, there were 12 investigators, all located in Winnipeg. Investigators interviewed during the course of our audit noted the difficulties associated with a lack of rural and northern investigators and the Department is currently taking steps to staff some positions outside Winnipeg.
- In 2006/07, the investigators conducted a total of 2,122 investigations: 406 intake investigations and 1,716 general investigations. Approximately one third of these investigations resulted in some kind of corrective action, such as recovering overpayments, adjusting or discontinuing benefits.
- Based on this 2006/07 activity, the Department estimated related cost savings of approximately $750,000, as well as additional savings in the form of future cost avoidance of $2,700,000. These estimates were based upon historical experience, although the underlying assumptions had not been recently validated.

4.4.2 There were information exchange agreements in place with other provinces and agencies to identify potential misuse of the EIA Program; however, there was room for further expansion in this area

- Information exchange arrangements with other provinces or agencies help to identify potential issues with respect to duplicate assistance and/or ineligibility.
- The Department has arrangements with Employment Insurance, Canada Pension Plan, Student Aid, Manitoba Justice (to identify incarcerated individuals), and Vital Statistics (to identify marriages), as well as income assistance programs in British Columbia, Alberta, Saskatchewan and Ontario. Additional information sharing with entities such as the Canada Revenue Agency, First Nation band welfare offices, and Child and Family Services might also be useful.

We recommend that the Department analyze the costs and benefits associated with expanding its current information exchange arrangements.

4.4.3 There were formal criteria for considering prosecution

- The Department has a Fraud Committee which considers whether or not cases with corrective action recommended for prosecution should be pursued. Current Committee membership includes the Program Standards Manager, a Program Specialist, and a District Office Director.
- Based on the terms of reference established for the Committee, prosecution is considered when an alleged fraud involves a deliberate act, fraudulent intent is clear, the amount involved is above a specified threshold, prosecution is in the public interest, and there are no persuasive mitigating circumstances.
- Prosecution may be initiated under the auspices of either the Employment and Income Assistance Act or the Criminal Code. Prosecution is relatively rare. For example, review of the Department's 2007/08 statistics showed charges were laid in 15 cases involving a total of approximately $377,000 and that there were 2 convictions involving total court ordered repayment of approximately $41,000. Departmental statistics are compiled in a manner such that annual convictions are not necessarily associated with the charges laid in that same year.

4.5 Managing Overpayments

Overpayments generally arise when EIA participants have received funds for which they are later found to be ineligible. As at March 31, 2008, departmental records indicated that, accumulated since the 1970s, there were 9,787 such cases with outstanding overpayments totaling $21.2 million yet to be collected. Approximately one third of these were open cases, where gradual repayment of the overpayments by way of manageable benefit deductions was in place. The other two-thirds were closed cases, with collection managed centrally by a single individual.

Overpayments were relatively stable over the last several years. Between March 31, 2004 and March 31, 2008, there was a 6.6% decrease in the total number of overpayment cases and an 8.6% increase in total overpayment dollars.

The average individual overpayment at March 31, 2008 was $2,168. However, individual outstanding overpayments varied considerably in value, ranging from a few dollars to $171,428. A relatively small number of cases accounted for a disproportionate share of the total overpayment dollar value: approximately 10% of the cases accounted for $13.6 million or 65% of the total overpayments of $21.2 million.

Observations and Conclusions

4.5.1 There were processes in place to detect and recover overpayments; however, opportunities existed to strengthen detection processes

- Departmental records indicated that overpayment recoveries in 2007/08 totaled approximately $3.1 million. Of this, approximately $2.0 million was recovered through benefit deductions on open cases and $1.1 million represented cash that was recovered on closed cases.
- The Department estimates that approximately 75% of the cash recovered on closed case overpayments is received through an agreement between the Department and the Canada Revenue Agency. This agreement allows the Agency to send applicable tax refunds, such as GST refunds, directly to the Department to be applied to outstanding overpayments. Closed case overpayments are also recovered through individual garnishee and voluntary payment arrangements.
- We selected a sample of larger dollar overpayments so as to obtain a better understanding of the circumstances which had led to these overpayments. These included overpayments identified within the current year and last few years, as well as overpayments dating back several years.

- The most common underlying reason for these overpayments was unreported spousal relationships and associated unreported spousal earnings discovered several years after the fact. There were also overpayments relating to unreported applicant income, children thought to be part of the family unit that had been taken into care by Child and Family Services, and immigration sponsorship arrangements.
- The majority of these larger dollar overpayments had been brought to the Department's attention by third party informants. The balance were discovered through program file review and home visits, information sharing, and an initiative whereby tax returns had been requested and received from the Canada Revenue Agency.
- In a limited number of cases, greater due diligence in following up unusual situations and case details may have detected the overpayments sooner. For example, in one case, the EIA participant's unreported earnings were from a job stemming from a job placement training program that had been provided to the participant and should have been monitored. In another case, the self-employment with nil earnings declared on an annual review form should have triggered further investigation when first reported.
- It was also noted that more regular periodic requests for income tax information from the Canada Revenue Agency and information sharing with Child and Family Services may have identified some of the overpayments sooner.

We recommend that the Department develop a process for more frequently requesting income tax information from the Canada Revenue Agency.

5.0 Benefit Payment Accuracy

The Regulations to the EIA Act set out the assistance rates that are to be paid to EIA Program participants in Manitoba. In addition, circulars are regularly issued by the Department to provide information to staff on program and policy changes.

Observations and Conclusions

5.1.1 Benefit payments were accurately calculated in accordance with prescribed rates in most cases

- Our audit work in this area involved reviewing files to ensure that the individuals receiving EIA benefits were receiving the amount they were entitled to, as prescribed by the Regulations to the EIA Act and Department circulars.

- Prescribed rates for the various categories of assistance were programmed into SAMIN such that the assistance amounts paid to Program participants were automatically calculated based on the participant information entered into SAMIN. This information was entered at the application stage and updated on an ongoing basis as required.
- We found a total of three irregularities in our sample. Two of the irregularities were related to incorrect rental amounts and one was related to an earnings exemption calculation. With respect to the rental irregularities, in one case the participant was being paid the rental amount for a four person subsidized housing unit, when, in fact, only three people resided in the unit. In the other case, one of the dependents had turned 18, which was not immediately reflected in SAMIN resulting in a one month overpayment. With respect to the earnings exemption calculation, there was no file documentation to allow us to verify the participant's employment income.
- We noted that in instances where vouchers were provided to program participants, usually in emergencies, there was sufficient supporting documentation in the file.
- We previously described the lack of documented supervisory file reviews in **Section 4.1.4**. Supervisory file reviews as required by the EIA Administrative Manual should include a review of benefit payment accuracy.

6.0 Referral and Monitoring Processes for Employment Enhancement Activities

One of the goals of the EIA Program is to assist EIA participants to become self-sufficient. Ultimately, this occurs when participants obtain suitable employment providing an income that, at minimum, equals the cost of their basic needs. The EIA Program works with participants to determine their barriers to employment and then direct them to appropriate training or education programs which will enhance their employability. However, it is the responsibility of the participant to find employment when there is an employment expectation.

Typically, the costs associated with these training or educational programs are covered by alternate means of financial support rather than the EIA Program. For example, an EIA participant may be eligible for student loans through Manitoba Student Aid. EIA participants continue to receive EIA benefits while taking part in approved training and education programs and may also receive additional benefits for transportation, clothing, and childcare.

Training and education expectations are included in the participant's action plan, which could mean sanctions or termination of benefits if the participant does not attend and complete what was agreed upon.

Observations and Conclusions

6.1.1 Participant work and education history was not always collected and/or entered into SAMIN

- In most cases, work and education information was appropriately collected on the EIA application form. Specifically, the application asked for the following information:
  - Education history;
  - Employment history;
  - Experience gained through training, volunteer work or employment; and
  - Barriers to employment (reasons the applicant cannot immediately work, if any).
- However, in 2% of the files that we reviewed, this information had not been appropriately collected on the application form. While this occurred in a relatively small number of files, it was a critical missing step in the skills development process. Complete information concerning educational and employment history is a necessary prerequisite in order to properly refer participants to appropriate training and education programs.
- In most instances, the application was completed electronically and SAMIN was automatically populated. Where a manual application was completed, caseworkers manually entered this information into SAMIN.
- SAMIN is a key source of information for caseworkers in determining appropriate training and education programs for participants. However, 4% of the files that we reviewed did not have the participant's education and employment history entered into SAMIN.

We recommend that the Department ensure that participant work and education history is properly collected and entered into SAMIN.

6.1.2 The Training and Employment Links System (TELS) is not being utilized to its full potential

- The Department maintains a database of agencies providing skills enhancement in a wide variety of disciplines. A listing of these agencies, with a description of the services offered, is available on the EIA Program's website.

- Caseworkers working in Winnipeg EIA offices have access to the Training and Employment Links System (TELS). This system is a database that interfaces with SAMIN to identify the available training programs most suitable for an EIA participant based on the information that has been recorded in SAMIN.
- TELS has the potential to be a powerful tool to assist caseworkers in referring participants to appropriate training and education programs; however, it requires accurate and complete information in SAMIN for it to operate properly. We found that some caseworkers entered more data into SAMIN than other caseworkers, and, as a result, TELS could not be relied on to provide consistent information for all participants.
- Some caseworkers did not have an adequate understanding of how to use TELS. During our review of files at one of the Winnipeg EIA offices, we found it difficult to find a caseworker with a working knowledge of TELS to provide us with an overview of how it worked.
- TELS is not available to caseworkers in rural EIA offices. Caseworkers in these offices rely on their experience and knowledge of participants to make appropriate training referrals. In many cases, rural caseworkers work closely with staff from the Department of Competitiveness, Training and Trade, which offers a variety of training programs suitable for EIA participants.

We recommend that the Department review the Training and Employment Links System in order to assess how best to increase use of this application.

6.1.3 Participant action plans were completed but some were not signed by caseworkers or were no longer appropriate

- Completion of an action plan is part of the EIA application process. An action plan outlines the applicant's responsibilities to the Program while in receipt of assistance. Action plans can range from simply ensuring that the Program is informed of all changes in the circumstances of the participant to more specific requirements, such as obtaining childcare or pursuing child support payments through the courts.
- In the files that we reviewed, we found that an action plan was consistently completed where one was required. However, in 8% of files where a plan was required, we found that it was either not signed (6%) or was no longer appropriate (2%).
- Action plans are to be signed by both the caseworker and the participant. In those instances where one or both signatures were missing, the action plan was not considered to be agreed to by both parties.

- In those cases where the action plans were considered no longer appropriate, the plans indicated only very general information such as "find/maintain employment", or the action plans were outdated and did not reflect the actual course of action being taken by the participants. Since in some cases, the purpose of an action plan is to guide an individual towards obtaining employment, it is important for it to indicate specific steps to be taken by the participant.

We recommend that the Department ensure that participant action plans are properly signed and updated.

6.1.4 Training documentation was incomplete and/or not approved

- At the time of our audit, caseworkers had the authority to approve pre-employment, job readiness, and skills training programs up to three months in duration and supervisors had the authority to approve training programs exceeding this duration. We selected a sample of files where participants had been referred to training or education programs. We found that 34% of these files were not properly approved for training or education programs less than three months in duration.
- We noted very few instances where EIA participants were referred to training or education programs exceeding three months in duration. In the sample of files we reviewed, only 6% of cases included a participant that enrolled in a program that exceeded three months. Of these, we found that 65% did not have the appropriate supervisor approval.
- In files where referrals were made to training or education programs, we expected to find documentation explaining the reasons why the participant was referred to a particular program. However, we found that in over 50% of the files we reviewed, the documentation was insufficient.
- Where an EIA participant was enrolled in a training or education program, we reviewed SAMIN to determine whether the starting and ending dates of the program were entered on the appropriate screens. For 21% of the files where participants were referred to a training or education program, we could not find the appropriate information entered into SAMIN.
- The training and education that participants are referred to is a very important step toward finding meaningful, long-term employment. The training is also a part of the participant's action plan. It is therefore imperative that the Program monitor the attendance and progress of the participants. In 38% of files where participants were referred to a training program, we were unable to locate documentation about the participant's attendance and progress.

We recommend that the Department ensure that all referrals to training programs are properly approved by caseworkers and supervisors, and accompanied by an appropriate explanation as to the reason for the training program.

We recommend that the Department ensure that participant attendance and progress in training programs is monitored and that this information, as well as participant work and education history, is recorded into SAMIN.

6.1.5 The number of EIA participants referred to training programs was low

- Caseworkers and supervisors informed us that they placed greater emphasis on having participants obtain employment and less emphasis on referring the participants to skills development or enhancement programs. In the sample of files that we reviewed, we noted that the number of EIA participants referred to training or education programs was low and only occurred in exceptional cases, such as where a participant could not speak English or had not completed high school.
- The Department informed us they are currently conducting a review to determine if a greater emphasis on training and education programs would lead to longer term self-sufficiency of participants.

7.0 Rate Setting Process

We expected the Department to provide funding to EIA participants in a manner consistent with the EIA Program objective of *"providing income assistance to Manitobans in need"*. We therefore expected there would be processes in place to periodically review and determine income assistance rates in a logical, structured, equitable and defensible manner.

Observations and Conclusions

7.1.1 Income assistance rates are subject to an annual review; however, the review process is not formally structured or documented

- The Department reviews income assistance rates annually. However, this review is not conducted in a formalized or prescribed manner, and is not summarized in a specific single document.
- The annual review considers the rates for shelter and basic needs, as well as the benefits available to EIA participants in specific situations. These include (but are not limited to) benefits such as essential drug, dental and

optical services, as well as allowances for school supplies, persons with disabilities, the high cost of healthy foods in northern and remote areas, and assistance in transitioning from income assistance to work. However, we noted that some less common allowances (e.g., allowances for various prescribed therapeutic diets) have not been reviewed for several years.

- Rates are not updated on a regular annual basis for all components of the rate structure for all recipient categories. Instead, based on the Department's assessment of need, rates are periodically updated for certain components of the rate structure relating to selected categories of recipients.
- The various levels of income and asset exemptions are also reviewed annually and periodically adjusted.
- EIA participants receive financial assistance for a variety of needs. Some items are covered by the EIA program based on their actual cost, while others are covered within set guideline rates that are not automatically adjusted for changes in actual costs. For example, the EIA Program pays the actual cost of a participant's utilities when utilities are not included in the participant's rent. However, the shelter benefits provided for rent are based on guideline rates that are not automatically adjusted for increases in actual costs. Participants receiving a shelter benefit including utilities do receive a higher rate than those whose rent does not include utilities, in recognition of those included utility costs.
- The Department conducts regular inter-provincial comparisons of the monthly basic and shelter rates for a variety of different household scenarios. The level of monthly assistance provided in Manitoba relative to other provinces (relative ranking) differs for each scenario. For example, the Department's January 2008 comparison contained eleven different scenarios that would be in effect for February 2008. **Figure 3** shows an excerpt of this inter-provincial relative ranking information.

Figure 3

	Manitoba Basic Rate ($)	Manitoba Shelter Rate ($)	Total Manitoba Basic and Shelter Rate ($)	Relative Provincial Ranking (of 10)
Single Parent - two children ages 10 and 13	602.40	430.00	1,032.40	4th highest
Two General Assistance Adults - two children ages 4 and 6	596.20	471.00	1,067.20	7th highest
Single Employable Adult	220.00	271.00	491.00*	8th highest
Single Person with a Disability	436.40	320.00	756.40**	7th highest

* includes $25/month job seekers allowance
** includes 35/month Manitoba Shelter Benefit and assistance of $105/month for persons with disabilities
Source: Department of Family Service and Housing January 2008 Inter-provincial Comparisons

- The Department also periodically reviews and considers the total benefit income obtainable by EIA participants from all available sources. This adds income related to federal child benefits and supplements and GST credits to the amounts shown in **Figure 3** above. In January 2008, the Department compared this total monthly benefit income to the total monthly benefit income available in August 1999 for the same household scenarios shown in **Figure 3**. **Figure 4** shows the resulting percentage change in benefit levels over this time period, in both actual and constant dollars.

Figure 4

	Total Income August 1999 ($)	Total Income February 2008 ($)	% Change Actual Dollars	% Change Constant Dollars
Single Parent - two children ages 10 and 13	1,253	1,618	29.1	13.6
Two General Assistance Adults - two children ages 4 and 6	1,288	1,753	36.1	19.7
Single Employable Adult	463	511*	10.4	-2.9
Single Person with a Disability	693	741**	6.9	-6.0

* includes $25/month job seekers allowance
** excludes $35/month Manitoba Shelter Benefit and includes assistance of $105/month for persons with disabilities
Source: Department of Family Service and Housing January 2008 Total Monthly Benefit Income Data

- The Department monitors various existing measures of poverty thresholds, although there is no "agreed upon" or official basis for measurement. In the absence of an agreed upon measure, one reference point sometimes used by both the Department and social policy advocates has been the Low-Income Cutoff statistics (LICOs) published by Statistics Canada. LICOs are a relative measure that approximate annual levels of income at which households of different sizes, in communities of different sizes, are forced

to spend a higher proportion of their income on the basic necessities of food, shelter and clothing than the average household would. We noted that a common criticism of this measure is that it places Winnipeg in the same community size category (populations of 500,000 and over) as cities such as Vancouver, Calgary and Toronto, without considering cost of living differences such as wide discrepancies in housing prices.

- The National Council of Welfare (NCW) is an arm's length advisory body to the Federal Minister of Human Resources and Social Development (HRSDC) on matters of concern to low-income Canadians. NCW issues periodic reports on patterns and trends in welfare incomes for four different types of households in the various provinces. For all provinces, reported welfare incomes fall below LICO thresholds. For example, the Summer 2006 report issued by NCW showed that 2005 welfare incomes in Manitoba ranged from 28% of the LICO for a single employable individual to 53% of the LICO for a couple with two children, ages 10 and 15.
- Recognizing the problems inherent in using LICOs as a poverty threshold, the Department also monitors, on an ad hoc basis, some of the various market basket measures of low income that are available. These are typically determined by selecting and pricing a set of goods and services deemed essential to a person's functioning in society and may vary considerably, depending on the types and number of items included in the basket, as well as the method of pricing used.
- Data published on the NCW website in June 2008 used a HRSDC market basket measure (MBM) that showed 2006 welfare incomes in Manitoba ranged from 44% of the MBM for a single employable individual to 83% of the MBM for a single parent with a two year old child. For all provinces, the NCW reported welfare incomes were closer to the HRSDC MBM threshold than the LICO threshold.
- While various low income threshold measures are monitored by the Department, they are not used as a direct input to income assistance rate-setting.

We recommend that the Department institute a formal documented process for reviewing and making recommendations for periodically updating basic and shelter rates, income and asset exemptions, and other income assistance allowances in a logical and equitable manner.

8.0 Departmental Response

The Department accepts the findings and recommendations made by the Office of the Auditor General in this report. The audit found that, overall the Department has processes to follow-up on concerns of program abuse and to detect and recover overpayments, accurately calculates benefits and clearly communicates program information. The report makes several recommendations to enhance procedures for obtaining and verifying financial information, documenting decisions, referring and monitoring training and reviewing rates. Over the past few years the Department has taken action to strengthen its accountability systems. This audit provides a useful road map for additional measures which could be taken to further improve accountability. The Department has made progress in a number of areas, including:

- *Hiring two investigators in rural and northern Manitoba and renewing its investigations procedures;*
- *Training more staff on procedures to detect fraud and abuse, such as undisclosed income;*
- *Doubling the money collected for overpayments on closed cases since joining Canada Revenue Agency's Refund Set-Off program in 2001;*
- *Strengthening the referral and monitoring processes for education and training programs under the Department's Get Ready! policy. As at June 2008, just over 1,600 participants were approved for education and training programs which are job focused. This represents an increase of approximately 20% over the previous time period;*
- *Providing staff with direction on when and how to provide assistance to persons without proper identification;*
- *Initiating a Quality Assurance Project to help ensure that the income assistance program is delivered in accordance with legislation, regulation, and policy;*
- *Creating new information sharing agreements; and*

- *Improving the Training and Employment Links System (TELS) to better match current participant skills with available jobs. The Department will examine extending TELS to rural and northern areas and will provide staff with resources to get people in job-related training.*

The Department will take the following actions:

- *By December 1, provide direction to staff which ensures they are aware of the expectations for documentation of annual reviews, home visits and identification and examine procedures for reviewing applications;*
- *By December 1, provide direction to staff reminding them to get a copy of two pieces of identification to confirm identity. In cases where copying is not possible, such as intakes in client homes or remote communities, staff will be directed to put a notation on file confirming that they reviewed the identification;*
- *Develop additional procedures to verify participant eligibility, including establishing a new standard for credit checks and income tax verification to be undertaken across the Province; and*
- *Work with Child and Family Services Authorities and their agencies to share information, respecting privacy provisions under The Child and Family Services Act.*

The Department reviews income assistance rates yearly as part of the budget process. The Department will develop formal criteria and internal processes for submitting recommendations to government for consideration during the development of the budget.

Health and Healthy Living

Chapter 2: Monitoring Compliance With The Ambulance Services Act

Table of Contents

1.0 Main Points

What We Examined

The Department of Health and Healthy Living funds the Ambulance Services program which is administered by the Regional Health Authorities. Ambulance Services provides emergency medical response and transportation services, by ground ambulance or air, for individuals in need. We examined the Department of Health and Healthy Living's processes for administering the provisions of *The Ambulance Services Act* and *Ambulance Services and Licenses Regulation* as they related to licensing, inspection and the minimum specifications for equipment.

What We Found

The Department of Health and Healthy Living was appropriately administering the provisions of *The Ambulance Services Act* and *Ambulance Services and Licenses Regulation* as they related to licensing, inspection and the minimum specifications for equipment with the following exceptions:

- There was no established process to ensure that ambulance service providers that held a provisional license were complying with the provisions of their license;
- There was no established process to ensure that ambulance attendants that held a probationary license were complying with the restrictions of their license;
- There was no licensing process for aeromedical pilots and aeromedical attendants;
- The Emergency Medical Services Branch (EMS) did not verify that all applicants for ambulance attendant licenses were at least 18 years old; and
- EMS did not verify that applicants for ambulance operator licenses held at least a class 4 driver's license.

2.0 Audit Approach

2.1 Audit Objective

The objective for our audit was:

- To determine whether the Department of Health and Healthy Living was appropriately administering the provisions of *The Ambulance Services Act* and *Ambulance Services and Licenses Regulation* as they relate to licensing, inspection, and the minimum specifications for equipment. **(Section 4.0)**

2.2 Audit Scope

Our audit focused on the processes in place as at December 31, 2005. Our audit procedures included interviews with staff of the Department of Health and Healthy Living and various Regional Health Authorities. We also reviewed and analyzed relevant files, records, correspondence and other supporting documentation.

3.0 Background

Ambulance Services provides emergency medical response and transportation services, by ground ambulance or air, for individuals in need.

Historically in Manitoba, *The Municipal Act* governed ambulance services and they were considered ancillary to the health system. A variety of agencies administered these services under the auspices of the municipal governments. Some examples of this were fire departments, service clubs, municipal "stand alone" corporations, proprietors and hospitals.

In 1996, *The Regional Health Authorities Act* transferred responsibility for the delivery of Ambulance Services from the municipal governments to the new Regional Health Authorities (RHAs). Under this legislation, the RHAs were given the responsibility to ensure that core health services were provided, including ambulance services. Many local services transferred ownership of all assets to the RHA. However, there were 22 "non-devolved" service providers that did not transfer asset ownership to an RHA. Although *The Regional Health Authorities Act* was drafted to allow for (but not require) entities to devolve into the RHA, administrative guidance identifies that the RHAs are still responsible for overall service delivery. Non-devolved service providers included a number of towns (municipalities), community councils, the City of Winnipeg, the City of Brandon, Manitoba Department of Conservation (at Falcon Lake), the Office of the Fire Commissioner, and CritiCare - a private company.

Since 1997, the RHAs have administered the Ambulance Services program and have received funding support from the Department of Health and Healthy Living. The ambulance service also charge user fees for basic calls and certain other transport services. The RHAs are responsible for planning and implementing emergency medical response services in their respective regions. The Emergency Medical Services (EMS) branch of the Department of Health and Healthy Living directs ambulance services in the Province of Manitoba.

Figure 1 illustrates the funding for ambulance services provided to the EMS branch and to the eleven Regional Health Authorities. Additionally, RHAs may allocate a portion of their annual global funding to emergency medical services.

That cost has more than doubled from over $28.5 million a year in 2003/04 to almost $59 million in 2007/08.

Figure 1

Fiscal Year	EMS Branch	RHA Funding	Total EMS Funding
2003/04	$5,095,200	$23,495,500	$28,590,700
2004/05	$5,660,000	$31,074,600	$36,734,600
2005/06	$5,998,000	$32,179,200	$38,177,200
2006/07	$5,616,800	$37,333,000	$42,949,800
2007/08	$6,288,000	$52,500,000	$58,788,000

Source: Manitoba Health Annual Report.

Subsequent Event

The program had been operating under *The Ambulance Services Act* and the *Ambulance Services and Licenses Regulation* during the period of our audit. The Ambulance Services program now operates under the authority of *The Emergency Medical Response and Stretcher Transportation Act*, which was proclaimed April 1, 2006. There are four regulations supporting *The Emergency Medical Response and Stretcher Transportation Act*:

- *Air Emergency Medical Response Systems Regulation;*
- *Land Emergency Medical Response System Regulation;*
- *Northern Patient Transportation Program Regulation; and*
- *Stretcher Transportation Services Regulation.*

We did not assess the impact of these changes on the processes we audited.

4.0 Licensing, Inspection and Equipment Specifications - Observations and Conclusions

In reaching the overall conclusions, we examined four key areas that relate to licensure:

4.1 Licensure of Ambulance Service Providers

4.2 Licensure of Ambulance Attendants and Ambulance Operators

4.3 Equipment Requirements

4.4 Inspections

Detailed audit criteria and observations are presented in the sections that follow.

4.1 Licensure of Ambulance Service Providers

Audit Criteria

The Department of Health and Healthy Living should have processes in place to ensure that all ambulance service providers are appropriately licensed.

Specifically we looked to determine whether:

There were licensing standards in place for ambulance service providers **(Section 4.1.1)**;

- There was a process in place to update the standard licensing requirements for new discoveries in the field or new best practices **(Section 4.1.2)**;
- There was a review process in place to ensure that ambulance service providers met the standard licensing requirements prior to receiving a license **(Section 4.1.3)**;
- There were processes in place to ensure that ambulance service providers that held a provisional license were complying with the provisions of the license **(Section 4.1.4)**; and
- There was a renewal process in place for ambulance service provider licenses **(Section 4.1.5)**.

4.1.1 Licensing Standards For An Ambulance Service Provider Were In Place

Ambulance service providers had to meet requirements set out in legislation before the Department would issue a license to them.

We reviewed the legislative requirements for ambulance service providers of two other provinces. There were similarities amongst them which included requirements to:

- Employ qualified individuals;
- Maintain insurance coverage; and
- Maintain records for personnel, finances, equipment and call reports.

These items were also included in Manitoba's requirements.

EMS personnel indicated that, in the case of a new applicant, they required additional information including:

- An organizational plan, with the following key components: staffing, training, medical direction, quality assurance;

- A plan for a system of receiving calls and dispatching the ambulance; and
- An organizational policy manual.

These requirements were not documented at the time of our audit, however, they are now included in the amended legislation.

4.1.2 A Committee Was In Place To Provide Input To The Update Process

In accordance with *The Ambulance Services Act* (Act) the Minister could, by regulation, establish standards for ambulance services. Therefore, the Minister of Health had the authority to set the standards as well as change them. The Department of Health and Healthy Living used the Manitoba Emergency Services Medical Advisory Committee (MESMAC) to recommend and advise on changes to applicable legislation.

MESMAC was established in order to provide medical guidance and system oversight at a time when there was a predominance of volunteers with minimal first aid training. MESMAC continues to advise on the standards for EMS and to review system-wide medical issues. Their main objective was *"to maintain public safety by ensuring safe practices by emergency medical responders and service medical directors"*. Their terms of reference included:

- Establish, review and evaluate provincial emergency medical care standards relative to the operation of emergency medical response services;
- Review, evaluate and establish standards for all equipment and adjuncts relative to the provision of emergency medical services;
- Define medical protocols, competency certification criteria, training parameters and quality assurance requirements for all emergency medical responder licensing levels; and
- Recommend and advise on changes to applicable legislation.

The committee was made up of 14 representatives from the medical community, RHAs, EMS managers, and Paramedic Association of Manitoba.

The terms of reference for MESMAC indicated that the committee was to meet six times per year, or every other month, unless there were insufficient agenda items. Upon review of the minutes of the committee meetings, we found that they had only met twice a year for each of the years 2003, 2004, and 2005. In lieu of meetings, there was evidence of regular email correspondence from the Provincial EMS Medical Director to each member of the committee regarding issues that had to be resolved.

4.1.3 Review Process Was In Place To Ensure Ambulance Service Providers Met The Licensing Requirements

EMS personnel indicated that they had a process to ensure that the ambulance service provider met the regulated requirements; however, these procedures were not documented.

The process included:

- Ensuring that there was a need for the service in that area;
- Ensuring that the ambulance service provider had the ability to meet the requirements; and
- The full inspection process as identified in **Section 4.4**.

There had not been any license applications since August 1999. The file review from this applicant indicated that:

- The applicant had provided documents that included necessary information to determine need for service in the area, as well as their ability to meet that need; however, there was no evidence of any analysis of the information by EMS; and
- EMS performed both a level 1 and level 2 inspection (see **Section 4.4**).

4.1.4 Provisional Ambulance Service Provider License Holders Not Reviewed To Ensure Compliance With Restrictions

EMS issued a provisional license to an ambulance service provider when the municipality and RHA for an area agreed that there was, or could have been, a need for an additional licensed ambulance operator for a certain area or in a certain situation. EMS licensed the applicant through the normal licensing process with the additional requirement of permission from the appropriate RHA to operate in that area.

EMS personnel indicated that because there were only three ambulance service providers with provisional licenses, they were able to monitor compliance on an informal basis. Those three were:

- The Office of the Fire Commissioner, who must be invited into a region to provide services;
- The City of Brandon, which had some Emergency Medical Technicians (EMTs) trained for transport between Winnipeg and Brandon, but did not have full EMT training to provide medical help for patients; and
- CritiCare, who had a license to provide ambulance service at Assiniboine Downs and Winnipeg Speedway.

The information that could have been used to formally monitor provisional licence compliance was available on call reports.

We recommend that the Department establish a formal review process to ensure that ambulance service providers with a provisional license are complying with the provisions of their license.

4.1.5 Annual Re-License Process In Place For Ambulance Service Provider License Holders

EMS had a re-license process in place for licensed ambulance service providers. This re-license process involved:

- Inspection by EMS;
- Approval by the RHA for the area (if "non-devolved");
- Approvals by the Director of Emergency Services and the Minister of Health; and
- Renewal issued prior to expiry of old license.

We examined the license files for three of the RHA ambulance service providers, four of the non-devolved ambulance service providers, and three air ambulance service providers. We found that the re-licensing process was appropriately applied for all ten providers.

4.2 Licensure of Ambulance Attendants

Audit Criteria

The Department of Health and Healthy Living should have processes in place to ensure that all ambulance attendants are appropriately licensed.

Specifically we looked to determine whether:

- There was a list of standard requirements that applicants must meet to qualify for an ambulance attendant license (Section 4.2.1);
- There was a process in place to ensure that these standard requirements were kept current and relevant for new discoveries in the field or new best practices (Section 4.2.2);
- There was a process in place to ensure that applicants met the requirements prior to the Emergency Services Branch issuing a license to them:
  - Land ambulance attendants (Sections 4.2.3, 4.2.4);
  - Air ambulance attendants and pilots (Section 4.2.5);
- There was a renewal process in place for ambulance attendant licenses (Section 4.2.6); and
- There was a process in place to ensure that ambulance attendants that held a restricted license were complying with the restrictions of that license (Section 4.2.7).

4.2.1 Standard Requirements For Ambulance Attendants Were In Place

Ambulance attendants had to meet requirements set out in legislation before the Department issued a license to them.

The Department of Health and Healthy Living had also developed a number of other documents that outlined requirements to be met. They had developed a licensing manual that detailed the licensing process for each type of license, and a syllabus for each of the Emergency Medical Responder (EMR) and Emergency Medical Technician (EMT) license levels. Also, they had developed Emergency Treatment Guidelines and Emergency Treatment Protocols to guide service delivery.

4.2.2 MESMAC Utilized To Keep Attendant Standard Requirements Updated

In accordance with the Act, the Minister could, by regulation, prescribe qualifications and other requirements that any applicant for a license must have or comply with. Therefore, the Minister of Health had the authority to

set the standards as well as change them. As noted in **Section 4.1.2**, MESMAC recommended and advised on changes to applicable legislation.

We reviewed the minutes of the meetings of the MESMAC for the years 2003, 2004, 2005 and found that they had reviewed authorized procedures for attendants during that time and implemented a number of amendments to better reflect current or best practices.

4.2.3 Exam Process Ensured Only Qualified Land Ambulance Attendant Applicants Were Licensed

The license process included both written and practical exams. EMS developed the written exam, which included several components and totaled 100 questions. Some of the components were standard so that they were in each exam. Other components were not standard. The process included EMS continually monitoring and surveying the RHAs to determine where there appeared to be deficiencies in attendant skills which could be the focus of the non-standard components of the exams.

The EMR practical exam consisted of five stations. Each station had a different practical skill that the attendant must demonstrate proficiency in. The skill stations were determined based on the monitoring and surveys of the RHAs to determine where there seemed to be deficiencies in the skills the attendants were showing.

The EMT practical exam consisted of two scenario stations and one skill station.

There was a process in place to ensure that land ambulance attendant applicants met the standard list of requirements. Qualified emergency medical services personnel facilitated and marked the exams.

We reviewed a sample of 30 applicant files. Of the 30, three were licensed as ambulance operators who were required to have basic first aid and CPR training and 27 files related to ambulance attendants who were required to have passed both the written and practical exams. We verified that the files contained evidence that all of these applicants met the necessary requirements.

4.2.4 No Verification That Attendants Were 18 Years Old Or Held A Class 4 Driver's License

Regulation required that a land ambulance attendant must be 18 years old. Land ambulance operators also were required to have a valid class 4 driver's license. EMS did require submission of a copy of the driver's license to verify it was a class 4 and to verify the age of the applicant; however, due to inconsistent practice, some were not received.

EMS personnel advised that they have reestablished the requirement for submission of a copy of the driver's license, as well as the applicant's original birth certificate.

4.2.5 No License Process In Place For Aeromedical Attendants Or Air Ambulance Pilots

There were a total of five air ambulance service providers, one of which was operated by the Department of Health and Healthy Living and four which were privately owned and operated.

The Act required that aeromedical attendants and air ambulance pilots be licensed. There were also specific requirements set out in the Regulation that the individuals had to meet in order to be licensed. However, EMS did not issue licenses for aeromedical attendants and air ambulance pilots. EMS advised that they requested air ambulance service providers to submit information on whether their employees met the requirements.

EMS did not verify any of the information provided, nor did they follow up if the providers did not submit the information.

Information was submitted by only two of the four private basic air ambulance service providers. One of the providers only listed the qualifications of their aeromedical attendants while the other sent supporting documentation.

There were 21 aeromedical attendants employed by these two respondents. They met the requirements set out in the Regulation as follows:

- 21 were either an RN or EMA III;
- 21 had the Basic Cardiac Life Support Certificate;
- 19 had the critical care or emergency nursing course or related experience;
- 17 had a Restricted Radio Telephone Operators License;
- 20 had completed the Aeromedical Escort Training Course; and
- 20 had completed the Aeromedical Specialist Registry Exam.

Only one of the air ambulance service providers submitted information for their pilots. They provided supporting documentation for the information submitted. Of the 11 pilots:

- 11 had a commercial pilots license;
- 11 were endorsed for multi-engine instrument flight;
- 11 had a valid pilot proficiency check on type;
- 5 had completed an aeromedical training course (documentation for the other 6 pilots was not available);
- 7 had Basic Cardiac Life Support Certification (documentation for the other four was not available); and

- None indicated the number of hours total flight time or the number of hours of multi-engine pilot in command.

We recommend that the Department establish a licensing process for aeromedical attendants and air ambulance pilots.

4.2.6 There Was A Renewal Process For Attendant Licenses

EMS had a re-license process in place for ambulance attendants. This process included requirements to renew at least every three years and to demonstrate they still met the standard requirements. The applicant could take the exam or the Alternative Route to Maintenance of Licensure (ARML). ARML was a combination of continuing education courses and experience obtained through attending ambulance calls.

We examined 30 license files. All 30 individuals had either passed the exam or provided the information required for ARML.

4.2.7 Monitoring Of Probationary Ambulance Attendant Licenses Not Conducted

EMS issued a probationary license when an ambulance attendant did not pass a portion (written or practical component) of the renewal exam. The attendant then had another opportunity to attempt that portion of the exam that they did not pass. The probationary license was in place until the applicant passed the component and was issued a license, or until the attendant failed the rewrite and the license expired.

The restrictions of a probationary license were that the attendant had to always be with a fully licensed attendant and was not allowed to be the primary attendant in the provision of care to patients. EMS did not have a process to monitor probationary attendant licenses.

We recommend that the Department establish a formal review process to ensure that ambulance attendants with restricted licenses are complying with the restrictions of their license.

4.3 Equipment Requirements

Audit Criteria

The Department of Health and Healthy Living should have processes in place to ensure that all ambulance vehicles/aircraft meet the specified equipment requirements.

Specifically we looked to determine whether:

- **There was a process in place to ensure that standard requirements in legislation for equipment and apparatus were kept current and relevant (Section 4.3.1);**
- **There was a process in place to ensure that only approved equipment or apparatus were used (Section 4.3.2); and**
- **There was a process in place to ensure that ambulance service providers were using all required equipment and apparatus (Section 4.3.3).**

4.3.1 MESMAC Utilized To Keep Equipment Requirements Updated

The Act and Regulation set out the requirements for equipment and apparatus that ambulance service providers must meet. MESMAC recommended and advised on changes to applicable legislation.

We reviewed the minutes of the meetings of the MESMAC for 2003, 2004 and 2005 and noted that the committee had:

- Established a subcommittee specifically to review new and different equipment;
- Reviewed the possible future use of a new type of equipment and subsequently recommended the use of it;
- Reviewed the current use of a piece of equipment and recommended the discontinuance of it; and
- Reviewed the proper use of supplies and recommended training for attendants.

4.3.2 Process To Inspect For Unauthorized Equipment In Place

EMS developed an inspection process that included a review for use of unauthorized equipment, apparatus or supplies. In this process, the inspector examined all equipment and apparatus in use in the ambulance and compared it to the list of approved items. EMS required the ambulance service provider to remove any items that were not included in the list of approved items. See **Section 4.4** for more details of the inspection process.

We reviewed inspection reports to assess whether only approved equipment or apparatus was used. Our examination of the inspection reports indicated:

- 19 vehicles in 3 RHAs were inspected. None were using unauthorized equipment;
- 12 vehicles in 7 privately operated ambulance stations were inspected. None were using unauthorized equipment; and
- 3 air ambulances in 3 ambulance stations were inspected. Of these, one carried unapproved medications. In this case, EMS asked the station to remove the unauthorized medications, which the station reported was done.

4.3.3 Process To Inspect For Required Equipment In Place

The inspection process also assessed whether all required equipment, apparatus and supplies were being used. In this process, the inspector examined all equipment and apparatus in use in the ambulance and compared it to the list of required items. EMS required the ambulance service provider to obtain, and include in the ambulance, any required items that were missing.

We examined the inspection reports for three RHAs. These included inspections of 19 vehicles. The inspection reports identified a total of 149 infractions.

The most frequent infractions were:

Figure 2

# of Infractions	Type of Infraction
11	The ambulance vehicle did not carry the required eight highway flares.
6	The ambulance vehicle did not carry at least one hand light for each attendant.
9	The ambulance vehicle had external light bulbs burned out (headlight, turn signal, amber flasher).
11	The ambulance vehicle had interior patient compartment lights burned out.
6	The certification for the fire extinguisher in the ambulance vehicle had expired.
8	The oxygen system was not secured properly in the ambulance vehicle.
6	The time calibration on the semiautomatic external defibrillator was incorrect.
10	The external defibrillator was not secured properly in the ambulance vehicle.
11	The ambulance vehicle did not carry a waterproof sheet.

We examined the inspection reports for 7 privately operated stations. These included the inspection of 12 vehicles. The inspection reports indicated a total of 64 infractions. The most frequent infractions were:

Figure 3

# of Infractions	Type of Infraction
7	The ambulance vehicle did not carry the required eight highway flares.
2	The ambulance vehicle did not carry at least one hand light for each attendant.
5	The certification for the fire extinguisher in the ambulance vehicle had expired.
4	The oxygen system was not secured properly in the ambulance vehicle.
5	The sterilization of burn bundles was outdated.
4	The ambulance vehicle did not carry hard hats for the attendants.
4	The ambulance vehicle did not carry two reflective vests.

We examined the inspection reports for 3 Air Ambulance stations. These included the inspection of 3 air ambulances. The inspection reports indicated a total of 6 infractions as follows;

Figure 4

# of Infractions	Type of Infraction
1	The air ambulance vehicle did not carry any size 7 sterile gloves.
1	The air ambulance vehicle was missing the required minidrip I.V. administration kit.
1	The air ambulance vehicle was missing one infant cuff for the portable sphygmomanometer.
1	The air ambulance vehicle was missing the Mucous trap suction.
1	The air ambulance vehicle did not carry opioid analgesic.
1	The air ambulance vehicle carried unapproved medications.

In each case, EMS requested that the ambulance service provider correct the infraction and, in each case, the ambulance service provider reported that they did. However, there was no scheduled follow-up by EMS until the next inspection. The frequency of inspections was determined based on risk, as explained in the following section of this report.

4.4 Inspections

Audit Criteria

The Department of Health and Healthy Living should have processes in place to ensure that inspection reports are being prepared on a timely basis.

Specifically we looked to determine whether:

- **Inspections were properly planned and performed in an appropriate, timely manner (Section 4.4.1); and**
- **There was a process in place to ensure results of inspections are reported to the Minister, and the ambulance service provider (Section 4.4.2).**

4.4.1 Adequate Process For Planning And Performing Inspections

EMS prepared an annual inspection plan which included a schedule of level one and level two inspections. Level one inspections were more administrative in nature and level two inspections involved an inspection of the vehicles, equipment and the physical station. EMS planned a level two inspection on each ambulance service provider every year, and a level one inspection at least every other year. Also, the inspections were prioritized so that in the event that not all inspections could be completed as planned, those of highest risk were conducted first.

Over the 2004 and 2005 license years, EMS performed a level two inspection on each ambulance service provider, which included 93 of 151 ambulance vehicles and related stations. They performed level two inspections on 2 of 27 vehicles and related stations in Winnipeg.

There was a documented inspection process in place. We examined the inspection files for 3 RHAs, 4 privately operated ambulance service providers and 3 air ambulance service providers. EMS followed the established inspection process for each inspection.

4.4.2 Appropriate Reporting Process for Inspections

We reviewed the inspection reports for those files that we examined in **Section 4.4.1** above. All of the inspection reports included a list of the deficiencies noted in the inspection; the recommended, or required, corrective action to be taken; the timeline when the corrective action should be taken; and a request for the service provider to verify by signature that they had received the report and that they had implemented all of the required recommendations for compliance.

5.0 Departmental Response

Emergency medical services (EMS) are an integral part of the health care delivery system in Manitoba and the Department of Health and Healthy Living (Department) is committed to ensuring that Manitobans access a safe and effective EMS delivery system. Recently, the legislation has been revised with the proclamation of The Emergency Medical Response and Stretcher Transportation Act, and we are pleased to report that in addition to other important improvements to the EMS system, the issues raised through the audit have also been addressed.

With respect to the exceptions identified by the Office of the Auditor General, the following measures have been implemented:

1. The Department has strengthened the requirements for provisional licensing of ambulance service providers and has established a formal process to ensure that ambulance service providers under the Air Emergency Medical Response System Regulation and Land Emergency Medical Response System Regulation are monitored for compliance to any restriction on their license. Provisional service license holder licenses may be issued for 1 - 12 months within a calendar year. Conditions applied to a provisional license are documented on the license and any specific requirements are documented to the service provider. Throughout the timeline of the provisional license the Department maintains frequent contact with the service and follow up to ensure conditions are met. Monitoring of the conditions of the license is also incorporated into the inspection program for the service.

2. The Department has established a process to ensure that personnel licensed under the Air Emergency Medical Response System Regulation and Land Emergency Medical Response System Regulation are monitored for compliance to any restriction on their license. Personnel and employers are provided with clear and specific written conditions of the provisional license including any restrictions in practice. Appropriate and timely monitoring is conducted by the Department.

3. The licensing process for aeromedical pilots and aeromedical attendants was put into place effective April 1, 2006. All aeromedical attendants and pilots are currently licensed in accordance to the requirements set out in the Air Emergency Medical Response System Regulation.

4. All applicants are now required to submit proof of age (e.g., verification with the submission of the applicant's Class 4 driver's license and birth certificate). The personnel application process confirmation checklist incorporates validation of proof of age.

5. The Highway Traffic Act and The Driver and Vehicles Act provide legislation in regards to the classification of license required to operate an emergency services vehicle. During the application process, the Department verifies that applicants have a Class 4 license. Additionally, all provincially licensed technicians are required under the Department of Health and Healthy Living Emergency Treatment Guidelines to be familiar with various Federal, Provincial, Municipal, and local laws, Regulations and Regional Health Authority policies affecting the operation of an emergency vehicle (ambulance).

Health and Healthy Living

Chapter 3: Pharmacare Program - Part 2

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Appendices

1.0 Main Points

This is the second part of the audit of the Provincial Pharmacare Drug Program (Pharmacare). The first part of the audit was released in the report *Audit of the Pharmacare Program: Manitoba Health* in April 2006 and reported on the following areas:

- Program management;
- Drug selection and cost;
- Physician prescribing practices and monitoring of drug use; and
- Reporting to the Legislature.

In 2004, members of the Canadian Council of Legislative Auditors (CCOLA) – Health Study Group (HSG) agreed to participate in a collaborative audit of the drug benefit programs in their jurisdictions. The objective of carrying out a collaborative audit was for each audit office to conduct their audits using common audit objectives and criteria which had been developed jointly by the participating auditors.

The overall purpose of the audit was to assess whether the Province of Manitoba (Province) has a cost effective program for managing Pharmacare.

Pharmacare is a universal, comprehensive, prescription drug benefit program for any Manitoban, regardless of age, who meets the deductible cost criteria for prescription drug costs. Manitoba is the only province in Canada which provides universal prescription drug cost coverage. The other provinces and territories limit coverage based on such criteria as age and income, or have a combination of private and public coverage.

In Manitoba, the objective of Pharmacare is to fund pharmaceutical benefits as provided for in *The Prescription Drugs Cost Assistance Act* and related regulations (Act). The Pharmacare Program protects residents of Manitoba from financial hardship resulting from expenses for prescription drugs.

Manitoba has had some form of prescription drug benefit program since 1971. Since 1996, the provincial drug program's eligibility and benefits have been determined by a person's family income and prescription costs incurred.

The utilization and cost of Pharmacare has increased significantly over the last number of years, with program costs increasing at a rate of 15-20% a year. Since 1998, the number of Manitoba families benefiting from Pharmacare has increased by more than 50% from 56,375 to over 87,600 in 2006. Seniors constitute the single largest group utilizing the Pharmacare program. In the same period, from 1998 to 2006, Pharmacare's budget has more than tripled - going from $62 million in 1998 to $207 million in 2006.

Main Conclusions

Program Eligibility (Section 4.0)

- The Provincial Drug Program (PDP), of the Department of Health and Healthy Living, had developed adequate processes to communicate the program terms and eligibility requirements to the public. However, there were opportunities identified to improve the communication process.
- PDP had adequate processes in place to ensure eligibility of the individual when they were initially registered with the Pharmacare program.
- PDP had adequate processes in place to verify ongoing eligibility of the insured person with the Pharmacare program, with the exception of changes to the person's third party insurance status (see Glossary).

Accurate Pharmacare Deductible Calculation (Section 5.0)

- Manitoba Health had a process in place to ensure that regulatory changes were reflected in the deductible calculation.
- Manitoba Health had adequate processes and procedures in place to ensure that the calculation of the family unit's Pharmacare deductible was accurate.

Manitoba Health's Process For Monitoring Pharmacy Claims (Section 6.0)

- PDP had an adequate process in place to ensure that pharmacies were being paid the proper amount for the cost of the drug claim.
- There was no monitoring performed of professional fees claimed. Consequently, there was no process to assess whether professional fees were in compliance with the Act and Regulations.

Accuracy And Validity Of Pharmacy Claims (Section 7.0)

- Manitoba Health had adequate processes in place to ensure that only accurate and valid claims were paid. However, the Pharmacare program was not in compliance with the requirements of the Act and regulations in regard to accounting for the recovery of drug costs by Pharmacare beneficiaries from third party insurance providers (see Glossary).
- Prior to June 2005, there was a lack of effective investigation and audit of the Pharmacare Program. Manitoba Health was in the process of developing this capability.

- PDP had a process to ensure that drugs used in contravention of *The Food and Drug Act, The Narcotics Control Act,* and *The Pharmaceutical Act* were excluded from the calculation of the deductible accumulator.

Pharmacy Processes For Compliance (Section 8.0)

All pharmacies used the Drug Program Information Network (DPIN) system. Controls within the DPIN system ensured that claims were accurate.

2.0 Audit Approach

The audit objectives for this second part of the Pharmacare audit were:

- To determine whether Manitoba Health had adequate processes in place to ensure the eligibility of a person insured under Pharmacare. **(Section 4.0)**
- To determine whether Manitoba Health had adequate processes in place to ensure the accurate calculation of the insured person's Pharmacare deductible. **(Section 5.0)**
- To determine whether Manitoba Health had adequate processes in place to ensure pharmacy compliance with the applicable sections of *The Prescription Drugs Cost Assistance Act,* and *The Pharmaceutical Act,* and their associated regulations. **(Section 6.0)**
- To determine whether Manitoba Health had adequate processes in place to ensure that only accurate and valid claims are paid. **(Section 7.0)**
- To determine whether the pharmacies are complying with the procedures and guidelines related to making accurate and valid claims. **(Section 8.0)**

We defined the scope of our audit as Manitoba's Pharmacare program (Pharmacare) which is responsible for the payment of the cost of drugs dispensed to eligible individuals who have purchased their drugs through retail pharmacies and met their Pharmacare deductible. Our audit did not include the other significant drug costs which are paid for by Manitoba Health for drugs provided to patients in hospitals and Personal Care Homes (PCHs) nor those paid for by the Department of Family Services for people on social assistance.

The audit covered the fiscal year ending March 31, 2006 and was conducted between July and December, 2006.

This audit was carried out under the authority of Section 14(1) of *The Auditor General Act* which states:

> *"In carrying out his or her responsibilities under the Act, the Auditor General may examine and audit the operations of a government*

organization with regards to any of the following matters:

a) Whether financial and administrative provisions of the Acts, regulations, policies and directives have been complied with;

b) Whether public money has been expended with proper regard for economy and efficiency;

c) Whether the Assembly has been provided with appropriate accountability information;

d) Whether the form and content of financial information documents is adequate and suitable."

3.0 Background

3.1 Introduction

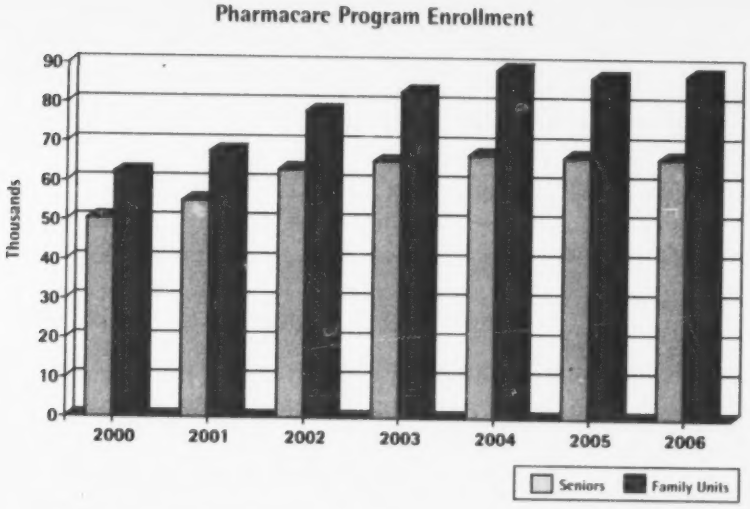
Pharmacare is a universal, comprehensive, prescription drug benefit program for any Manitoban, regardless of age, who meets the deductible cost criteria for prescription drug costs. Manitoba is the only province in Canada which provides universal prescription drug cost coverage. The other provinces and territories limit coverage based on such criteria as age and income, or have a combination of private and public coverage.

In Manitoba, the objective of Pharmacare is to fund pharmaceutical benefits as provided for in *The Prescription Drugs Cost Assistance Act* and related regulations (Act). The Pharmacare Program protects residents of Manitoba from financial hardship resulting from expenses for prescription drugs.

Manitoba has had some form of prescription drug benefit program since 1971. Program benefits between 1971 and 1995, were based on a combination of flat rates and deductibles, with seniors having a lower flat rate and deductible. Since 1996, the provincial drug program's eligibility and benefits have been determined by a person's family income and prescription costs incurred. (see **Appendix B**)

The utilization and cost of Pharmacare has increased significantly over the last number of years, with program costs increasing at a rate of 15-20% a year. Since 1998, the number of Manitoba families benefiting from Pharmacare has increased by more than 50%, as illustrated in **Figure 1**. The percentage of seniors enrolled in the program has similarly increased.

Figure 1



3.1.1 Legislative Authority

Authority for the Pharmacare program has been enacted in *The Prescription Drugs Cost Assistance Act* (Act) and the associated regulations:

- Regulation 60/96 Prescription Drugs Payment of Benefits Regulation; and
- Regulation 6/95 Specified Drugs Regulations.

The dispensing of drugs through retail pharmacies is also governed by parts of *The Pharmaceutical Act*.

3.2 Organization

The Pharmacare program is administered under the Department of Health and Healthy Living (Manitoba Health) by the Provincial Drug Program Branch (PDP).

PDP also administers the following programs:

- Palliative Care Drug Access Program;
- Personal Care Home Drug Program;
- Family Services Drug Program; and
- Ancillary Programs which includes: Breast Prosthesis Program, Children's Hearing Aid Program, Senior's Eyeglass Program, Telecommunication Devices, Children's Orthopedic Shoes Program, Infant Contact Lenses, Artificial Eyes, Prosthetic and Orthotic Devices.

Funding for the Personal Care Home Drug Program and Family Services Drug Program are not included in the PDP budget.

PDP manages the Drug Programs Information Network (DPIN) for all four drug programs, the list of eligible drugs (including updating and additions for new/removed drugs), and claims procedures for prescriptions filled under the four drug programs.

Since 2006, PDP is comprised of three functional units:

- Operations Management;
- Professional Services; and
- Drug Management Policy.

3.3 Program Delivery Structure

3.3.1 Eligibility

The Pharmacare program is a universal drug benefit program established to protect all eligible residents from financial hardship resulting from expenses for prescription drugs. Eligibility is based on the individual meeting the following criteria:

- Eligible for Manitoba Health coverage (resident of Manitoba);
- Prescriptions are not paid by other provincial or federal programs;
- Prescription costs are not covered by private or other drug insurance programs; and
- Eligible prescription costs exceed a person's Pharmacare deductible.

3.3.2 Deductible And Formula

Unlike residents in other jurisdictions, Manitobans do not pay premiums or co-payments for their drugs. Instead, Pharmacare coverage is based on the total family income and the amount that a person has paid for eligible drugs in the year. Each family is required to pay their prescription drug costs until their annual deductible as calculated by the program, is reached. Once a family has reached their deductible, Pharmacare pays 100% of the eligible prescription drug costs directly to the pharmacy that dispensed the drugs.

The formula for the deductible calculation is presented in Regulation 60/96, *Prescription Drugs Payment of Benefits*, in Section 6(1) (see **Appendix B**). The total family income of the year ending 2 years prior to the year that benefits are being applied for is used to determine the deductible amount. As an example, for benefit year 2005/06, total income would be that reported on the 2003 tax return.

Family income is confirmed by means of the Canadian Revenue Agency (CRA) Notice of Assessment. The total family income is reduced by $3,000 for an eligible spouse and $3,000 for each dependant to arrive at an adjusted family income.

The adjusted family income is then multiplied by the appropriate deductible percentage, as set out in Regulation 60/96 S.6(1)b to calculate the family deductible. The formula for the deductible is varied according to family income; in 2005/06 the rates used varied from a minimum of 2.32% of family income up to $15,000 to a maximum of 5.00% for family income greater than $75,000. There is a minimum $100 deductible.

3.3.3 Application For Pharmacare Coverage

A Pharmacare application and consent authorization form must be completed for all family units. This application may be made annually, or through a one time enrollment process. The application identifies all members of the family unit over 18 through the use of the Personal Health Information Number (PHIN). A copy of the Manitoba Pharmacare application form is provided in **Appendix C**.

The Manitoba Pharmacare application form requires the applicant to provide:

- all relevant family unit information;
- all relevant family unit income information or authorization for the Department to receive the information directly from the CRA; and
- a declaration that drug costs submitted to Pharmacare are not covered by another third party insurer or other drug benefit program.

3.3.4 Billing

According to the Act, Pharmacare is to be the secondary payer after drug insurance companies and other public drug programs (see **Section 7.1.2**). Prescriptions filled at pharmacies in Manitoba are entered into the pharmacy's practice management software, which is electronically linked with the DPIN system. DPIN keeps track of all eligible prescription drug costs attributed to an individual and their family unit.

Once the total in this Pharmacare deductible accumulator reaches the family unit deductible, the prescription costs are billed directly to Pharmacare through the DPIN system. Pharmacare reimburses the pharmacy for the cost of the drug, plus the dispensing fee.

Drug costs for patented drugs are monitored according to guidelines set by the Patent Medicine Price Review Board (a national body) to determine compliance with guidelines set by the Board. For generic drugs, the price is set by the manufacturer, and Manitoba Health reimburses the pharmacy for the lowest generic cost of the product. Pharmacare sets the price at which it will reimburse

pharmacies as the maximum allowable price. There is no limit on the dispensing fee that a pharmacist may charge Pharmacare, except that the fee charged to a Pharmacare client should not exceed that which is charged to a non-Pharmacare client.

The Canada Health Act requires the provinces to cover the cost of all drugs administered within hospitals and Personal Care Homes (PCHs).

The Department of Family Services and Housing pays 100% of the costs of eligible prescriptions for persons on social assistance.

4.0 Program Eligibility

We reached the following overall conclusions on the program eligibility audit objective and criteria:

Audit Objective and Criteria	Conclusions
To determine whether Manitoba Health had adequate processes in place to ensure the eligibility of a person insured under Pharmacare. In particular, whether:	Manitoba Health had adequate processes in place to ensure the eligibility of a person insured under Pharmacare.
4.1 Communicating program terms and eligibility Adequate processes should exist for communicating program terms and eligibility requirements to the public.	PDP had developed adequate processes to communicate the program terms and eligibility requirements to the public. • Program information and eligibility requirements were readily available through the Pharmacare website, maintained by the Department of Health and Healthy Living; • There were well developed processes to ensure individuals new to the province or who had turned 18 years old were aware of the program; and • The application form included all relevant information required to enable an individual to enroll in Pharmacare. However, there were opportunities to improve the communications process. • PDP had no documented communications strategy for the Pharmacare program; • PDP had not formally identified any key client groups for Pharmacare information to be communicated to; • Pharmacists were identified as key in informing clients about Pharmacare, as opposed to Manitoba Health; and • Pharmacists indicated that they mainly rely on their own experience for information about Pharmacare rather than on information supplied by Manitoba Health. Pharmacists also stated that they felt the potential exists that there may be Manitobans who might not be aware of the benefits of the Pharmacare program.

Audit Objective and Criteria	Conclusions
4.2 Processes to verify initial eligibility Adequate processes should exist to verify eligibility when first registering with the Pharmacare program.	PDP had adequate processes in place to ensure eligibility of the individual when they were initially registering with the Pharmacare program. This was accomplished by: • Ensuring the validity of Manitoba residency was confirmed; • Verifying the individual's Manitoba Health number; and • Verifying the initial eligibility information requested on the application form.
4.3 Processes to verify ongoing eligibility Adequate processes should exist to verify a person's eligibility throughout the period of time receiving benefits.	Adequate processes exist to verify a person's eligibility throughout the period of time receiving benefits. • PDP verified client information on an ongoing basis to data from outside the Department; but • PDP did not have a process to detect or verify an individual's third party insurance status.
4.4 Policy and Procedures Manuals A comprehensive policies and procedures manual that is consistent with the Act and its regulations should be in use and updated regularly.	The policy and procedures manuals used by PDP customer service representatives were consistent with the Act and regulations. However: • The policies and procedures were not subject to regular updating; and • The manuals were not standardized.

In reaching the overall conclusion, we examined four key areas that related to Manitoba Health's process to ensure program eligibility:

4.1 Communicating Program Terms and Eligibility;

4.2 Processes to Verify Initial Eligibility;

4.3 Processes to Verify Ongoing Eligibility; and

4.4 Policy and Procedures Manuals.

Detailed audit criteria and observations are presented in the related sections.

4.1 Communicating Program Terms and Eligibility

Audit Criteria

Adequate processes should exist for communicating program terms and eligibility requirements to the public. Specifically, we looked to determine whether:

- The Provincial Drug Program (PDP) had a documented communication strategy for the communication of Pharmacare program benefits to the public **(Section 4.1.1)**;
- PDP had attempted to identify its key client group (persons likely to qualify) and had tailored its communication strategy and information process to ensure that this group had access to the PDP information, and the opportunity to apply for benefits **(Section 4.1.2)**;
- There was a process to provide information and application forms to the public regarding Pharmacare eligibility requirements and the application process **(Section 4.1.3)**; and
- The Pharmacare application form included all relevant requirements for eligibility **(Section 4.1.4)**.

4.1.1 No Documentation Of Pharmacare's Communication Strategy

Information about Pharmacare had been circulated to residents of Manitoba, as a part of the "Manitoba Health Information Guide" issued by Manitoba Health. Program information was also readily available through the Department of Health and Healthy Living website, although this was only available to people with internet access.

We did review the Pharmacare website and compared it to the drug program websites of most of the other provinces for ease of access to information. We found that Manitoba's Pharmacare web site compared favourably to those other provinces. It offered easy access to eligibility conditions, an explanation of benefits, and sufficient information to allow an individual to begin the registration process. Contact numbers for further information were easily located.

Manitoba Health also had a process in place to ensure that individuals new to the province or who have turned 18 were made aware of the program. This awareness was accomplished by providing information about Pharmacare to individuals who have recently arrived in Manitoba and were applying for a Manitoba Health Card. Individuals who were part of family unit were provided information about the program as part of the information package Manitoba Health provided when

they reach 18 years of age and became eligible for their own Manitoba Health Registration number.

PDP officials advised us that there was no documentation of a communication strategy.

Without a formally documented communication strategy, the aims and objectives of the Pharmacare program may not be achieved. A lack of formal documentation could also lead to differing interpretations of the aims and objectives as noted in the following sections.

We recommend that there should be a documented communication strategy.

4.1.2 No Formal Identification Of Key Client Groups

The Pharmacare Program has identified their target group as individuals with high drug costs in relation to income. Officials of the The Pharmacare Program have indicated that this would include seniors, low income earners and middle income earners with high drug costs. The Pharmacare Program did not specifically document their identification of target individuals or groups.

Officials advised that there was an implicit recognition that the program's focus on providing relief against high drug costs to low income earners means that seniors are a key group. However, we note that as a group, some seniors and low income earners may not have the means to have access to Pharmacare's internet based program information.

Although PDP provides information over the telephone regarding the Pharmacare program and eligible drugs on an ongoing basis, PDP management identified pharmacists as being the main method of informing Manitobans of the benefits and eligibility requirements for Pharmacare, given the frequency of contact and individual rapport with clients when obtaining prescriptions. Pharmacists advised that they encountered individuals having prescriptions filled on a regular basis who were not aware of Pharmacare until they were informed of the program by the pharmacist.

We recommend that the communication strategy appropriately address the needs of all client groups.

4.1.3 A Process To Provide Program Information To The Public Existed

Pharmacare had a process to communicate information and application forms to the public. The primary methods used were through the general information contained in the "Manitoba Health Information Guide", the website, and the application form itself. Officials and staff advised that Customer Service

Representatives (CSRs) at Manitoba Health answer most customer inquiries about the program. There were staff available to assist non-English speaking individuals.

PDP had taken steps to ensure that individuals who are hard of hearing have access to the information that they require to enroll and receive benefits, through provision of such services as Telephone Access for the Deaf.

First point of contact for the program is the Pharmacist. Officials advised that pharmacists have a key role in the communication process, as they were the individuals most likely to be in contact with potential clients. PDP management frequently mentioned this reliance on pharmacists, especially in assisting enrollment of individuals into the program and in answering any questions that the client might have.

We inquired of the pharmacists about their views on the current communication process. Pharmacists indicated that they were able to answer most questions clients had about the program. PDP support was helpful for those questions which they did not have an answer for. However, of the 35 pharmacists interviewed, 31 indicated that they thought some type of information brochure would be useful for answering common questions that the clients had. This would allow the client to have something to refer to after meeting with the pharmacist. It would also free up time which the pharmacist indicated they would normally spend answering the client's basic questions about the program.

4.1.4 Application Form Included All Relevant Eligibility Requirements

Relevant sections for eligibility requirements are laid out in *The Prescription Drug Cost Assistance Act*, Regulation 60/96 2(1). These requirements are:

- The individual must be a resident of Manitoba, as defined under *The Health Services Insurance Act*;
- The individual must be a member of family unit which has collectively spent more on drugs than the deductible determined by the formula in the regulation; and
- An application to become eligible has been made.

We reviewed the Pharmacare application form (**Appendix C**) and noted that the terms and conditions of eligibility were clear and concise and were included on the Pharmacare application form through the following process:

- Residency was confirmed by the applicant having a Manitoba Health Registration number (see **Section 4.2.1**); and
- Only one application was to be completed per family unit. Family members were then linked in Drug Program Information Network (DPIN) through the

use of the Manitoba Health numbers and the Personal Health Identification Number (PHIN).

4.2 Processes to Verify Initial Eligibility

Audit Criteria

Adequate processes should exist to verify eligibility when first registering with the Pharmacare program. Specifically, we looked to determine whether:

- **An application process was in place for persons to apply for Pharmacare benefits which requested all relevant information in order for the Department to be able to assess the person's eligibility (Section 4.2.1);**
- **Adequate processes were in place to determine whether a person was eligible to receive benefits under the Pharmacare Program (Section 4.2.2); and**
- **Adequate procedures were in place within the Registration Section of Manitoba Health for the issuance of Manitoba Health numbers to applicants (Section 4.2.3).**

4.2.1 Application Process Included A Request For All Relevant Information Required To Assess Eligibility

The Pharmacare program's application process was dependant on Manitoba Health's registration system to ensure that all applicants have valid PHINs. The PHIN was vital, as Manitoba Health's registration process ensured that PHINs were issued only to valid Manitoba residents. This was also a key component of the Pharmacare eligibility requirements (see **Section 4.2.3**).

Other eligibility information was requested via the application form and included Social Insurance Number, marital status, and family unit income information. This information was verified by PDP to outside sources in order to ensure that the family unit and income was being set up and tracked correctly within DPIN.

4.2.2 Process Existed For Verification Of Eligibility Requirements

PDP had adequate processes in place to verify eligibility for Pharmacare applicants. As indicated in **Section 3.1.4**, the requirements for eligibility were set out in Prescription Drug Payment of Benefit Regulation 60/96.

PDP relied upon verification of residency and members of the family unit through information obtained and updated by the Manitoba Health registration system. The PDP process verified the initial eligibility information supplied by

the applicant to the database in Manitoba Health to ensure that only eligible residents were enrolled, that all members of the family were included for purposes of tracking costs incurred, eligible benefits paid, and proper deductible calculation. Information regarding family income and marital status was also confirmed with the Canadian Revenue Agency (CRA).

All prescription drug costs attributable to the family unit were tracked in DPIN to determine when the deductible was met and the family unit was eligible for Pharmacare benefits.

We assessed the specific procedures used for individuals who were Federal drug program beneficiaries, eligible for other Provincial drug program benefits and who had other third party (see Glossary) prescription drug benefit insurance as follows:

- Family units with members eligible for reimbursement of drug costs under federal or other Manitoba drug plans were identified in DPIN. For Federal drug program beneficiaries, the individuals were not enrolled by the registration section of Manitoba Health. These individuals were given an inactive PHIN, and remained part of the family unit for purposes of calculation of the deductible. The costs of any prescriptions covered by federal drug benefit programs were not included in the accumulation of costs paid by the family unit towards the Pharmacare deductible. This process is consistent with the Act.
- Individuals eligible for other Manitoba drug benefits (e.g., through PCHs or Family Services) were identified within the DPIN system. In these cases, claims would then be processed under the appropriate provincial drug plan, and not through Pharmacare.
- For individuals who had third party prescription drug insurance, PDP relied upon the applicant to sign a declaration as part the application form (see **Appendix C**) that those costs paid by the third party insurer would not be submitted to Pharmacare. We had concerns regarding the accounting for this third party insurance process which will be discussed further under **Section 6.0**.

We conducted a test of a random sample of 65 new applicants during the period under audit, tracing the information in DPIN back to the initial application request and verifying the details to the Manitoba Health registration database and to data supplied from the Canadian Revenue Agency. Our test confirmed that the controls PDP had in place were functioning to verify an individual's initial eligibility.

4.2.3 Adequate Process Was In Place To Ensure Only Manitoba Residents Were Issued PHINs

The Manitoba Health Registration section had adequate procedures in place to ensure that only Manitoba residents were issued PHINs. The Registration section had processes in place to ensure that only valid residents, including residents who were turning 18 years of age and were members of a family unit with the adults holding valid PHINs, were added or removed from the list of active PHINs. Manitoba Health confirmed residency and family unit information through data provided by Vital Statistics.

For individuals moving to Manitoba from within Canada, there was a process in place to ensure they had continued health coverage. They were covered under their previous provincial plan for the month they moved to Manitoba, plus an additional two months. For individuals immigrating to Canada, coverage was extended only if they had permanent residence status or a valid work permit.

As the definition of residence utilized by the Registration section was the same as that used in the Pharmacare program, the process used to determine residence for issuing a PHIN provided sufficient assurance that only Manitoba residents who held a valid PHIN were eligible for Pharmacare.

4.3 Processes to Verify Ongoing Eligibility

Audit Criteria

Adequate process should exist to verify a person's eligibility throughout the period of time receiving benefits. Specifically, we looked to determine whether:

- Pharmacare had an ongoing process within the Department to monitor the eligibility status of persons receiving benefits from the Pharmacare program (Section 4.3.1); and
- Pharmacare had processes to detect a change in eligibility status of persons receiving benefits from the Pharmacare Program from sources outside of the Department or if not reported by the person, including change in:
  - Residency;
  - MH Registration;
  - Change to Family unit; and
  - Coverage by other Drug Benefit Programs (Section 4.3.2).

4.3.1 Adequate Monitoring Of Individual Eligibility, Except For Third Party Insurance Coverage

PDP had well developed processes to monitor the eligibility of individuals enrolled and receiving benefits. Monitoring was accomplished primarily through the processes used by the registration section, including verification of data to Vital Statistics and CRA. Self-reporting by the client was also utilized to initiate changes in the eligibility status. There were processes in place to ensure that data was shared between provinces, minimizing the risk of an individual leaving Manitoba but continuing to collect benefits. All verified changes processed by the registration section were downloaded into DPIN on a daily basis. The monitoring process was useful in detecting and flagging eligibility changes which need to be followed up on.

However, there was a deficiency in monitoring the changes in third party insurance coverage. As in the case of the initial eligibility verification, there were no processes in place to ensure that an individual already enrolled in the program and who became eligible for third party insurance would be detected. PDP had no processes in place to utilize any such information, even if detected.

We recommend that a monitoring process be implemented to detect individuals who acquire third party insurance coverage.

4.3.2 Adequate Processes To Detect Changes In Eligibility, Except For Third Party Insurance Status

PDP had processes in place to detect a change in residency, in Manitoba Health Registration, and to the family unit. Most were performed through the Manitoba Health registration section, which handled self reported changes in status as well as verifying reported and unreported changes to the Vital Statistics database. There was a process to verify information to CRA supplied data. This data was useful for ensuring reporting of changes in marital status, province of residency and for verifying family unit income. Many of these changes were also reported by the individual directly to PDP.

For changes in third party drug coverage, the processes varied:

- For most Federal programs, and other Manitoba provincial programs, the program had well developed processes to ensure that any changes were detected. This process occurred through on-going verification of the CRA and DPIN databases;
- For out of province claims, the registration section of Manitoba Health investigated to ensure that they were valid before passing them to PDP for payment; and

- For other third party insurance coverage, detection of changes to an individual's coverage was primarily the result of the individual reporting the change. This was usually communicated to the pharmacist and rarely was PDP informed. PDP had no process in place to communicate directly with the third party insurers to monitor or compare the individuals receiving benefits. PDP management also indicated that, in the very rare cases where the client informed them of a change, there was no field in DPIN in which the information could be entered.

Other than self-declaration of third party insurance coverage on the application form, Manitoba Health had no method for clients to report on their third party insurance coverage. It was possible for an individual to receive reimbursement from a third party insurer for amounts being attributed towards their Pharmacare deductible accumulator.

We recommend that Manitoba Health should implement a process for reporting and updating third party insurance coverage.

4.4 Policy and Procedures Manuals

Audit Criteria

A comprehensive policy and procedures manual that is consistent with the Act and its regulations should be in use and updated regularly. Specifically, we looked to determine whether:

- The Provincial Drug Program (PDP) maintained adequate policy and procedures manuals, which detailed the policies and procedures of the administration of the program with regards to:
  - terms and conditions of eligibility;
  - the application process;
  - the method of calculating the deductible; and
  - the reimbursement process (Section 4.4.1).
- PDP had a process to ensure that procedures manuals were regularly updated to accurately reflect changes in the applicable Acts and regulations and changes in administrative practices (Section 4.4.2).

4.4.1 Policy And Procedures Manuals Were In Use, But Were Not Standardized

The PDP policy and procedures manuals included sections on initial processing of the application. The manuals were focused primarily on the procedures around changes to the information reported on the initial application (such as, family unit income, dependents, or marital status), procedures for reimbursing individuals who have applied late in the benefit year and manual claims processing.

All deductible calculations were performed automatically within DPIN. This information, therefore, was not included in the policy and procedures manual.

The policy and procedures training manual was not standardized. Customer Service Representatives (CSRs) were allowed to "customize" the documentation of policies and procedures by including or excluding information so that they could organize and access the data in a manner which they felt comfortable with. There were also no specific guidelines to indicate which policies and procedures should be included in the CSR's manual.

Allowing the customization of manuals may result in policies and procedures intentionally excluded or omitted in error. This could result in differing interpretations of the policies and procedures between individual CSRs.

We recommend that manuals be standardized to ensure the consistency and inclusion of all necessary information.

4.4.2 No Formal Process For Updating Policy And Procedures Manuals

PDP management indicated that there was no formal policy or process to update policy and procedures manuals; new policies and procedures were added as they were introduced.

When the policy and procedures manuals were updated, it was done in an inconsistent manner. For example, there was evidence of updating to some of the standards in the processing manual in the form of e-mails. However, both the processing manuals and DPIN training manuals that were examined had large sections in which no updates appear to have been included since the manuals were originally issued (1998-1999). There were handwritten procedures contained in the manual with no indication of their issuing authority or effective date.

PDP management stated that the older policies and procedures maintained in the manuals were still current. Indication that PDP had reviewed these to ensure their continued current relevance would be highly desirable.

We recommend that Manitoba Health implement a formal process to ensure policy and procedures are updated on a regular basis.

5.0 Accurate Pharmacare Deductible Calculation

We reached the following overall conclusions in relation to the Pharmacare deductible audit objective and criteria:

Audit Objective and Criteria	Conclusions
To determine whether Manitoba Health had adequate processes in place to ensure the accurate calculation of the insured person's Pharmacare deductible. In particular, whether:	Manitoba Health had adequate processes in place to ensure the accurate calculation of the insured person's Pharmacare deductible.
5.1 Deductible calculation in relation to the Act and regulation Manitoba Health should have adequate processes in place to ensure the accurate calculation of the program deductible in relation to the applicable Act and regulation.	• Manitoba Health had a process in place to ensure that changes in the regulation were reflected in the deductible calculation; and • Controls in place over the deductible calculation were also found to be adequate.
5.2 Deductible calculation in relation to the family income level Manitoba Health should have adequate processes in place to ensure the accurate calculation of the client deductible amount in relation to the family unit annual income, as reported to Canadian Revenue Agency (CRA).	• There were adequate process in place to ensure that the deductible calculation was accurate; and • Family unit income information was also verified to ensure the accuracy of the deductible calculation.

In reaching the overall conclusions, we examined two key areas that relate to ensuring Manitoba Health's pharmacare deductible calculation is in compliance with the Act:

5.1 Deductible calculation in relation to the Act and regulation; and

5.2 Deductible calculation accurately reflected the family income level.

Detailed audit criteria and observations are presented in the related sections.

5.1 Deductible Calculation in Relation to the Act and Regulation

Audit Criteria

Manitoba Health should have adequate processes in place to ensure the accurate calculation of the program deductible in relation to the applicable Act and regulation. Specifically, we looked to determine whether:

- **Manitoba Health had a process in place to ensure that all regulatory changes to the deductible calculation were made in a timely fashion (Section 5.1.1); and**
- **Manitoba Health had controls in place to ensure that the deductible calculation was consistent with the formula outlined in Regulation 60/96 (Section 5.1.2).**

5.1.1 Regulatory Changes Affecting The Deductible Calculation Were Made In A Timely Fashion

PDP officials advised that there was a process to ensure that regulation changes were in place prior to the effective date of the regulatory amendment. There was no formal documentation for changes to the regulation. Initiation of any changes occurred during the annual budgeting process, and the changes must be approved by the government, not PDP. Once PDP received the signed regulation or amendment, the changes were forwarded to the IT department who entered the changes into DPIN with their effective date. No change to the regulation occurred during the time of our audit work, July to December 2006.

5.1.2 Controls Over Deductible Calculation Were Consistent With The Act

The Pharmacare program had controls in place to ensure that the deductible calculation was consistent with Regulation 60/96. Updates to the percentages used to calculate the family unit deductible were changed in DPIN as required by approved amendments to the regulation.

We re-performed the deductible calculation for a sample of 40 family units from data obtained from DPIN. The recalculation was performed in accordance with the process outlined in the regulation. There were no instances noted where the calculation was incorrect.

5.2 Deductible Calculation In Relation To The Family Income Level

Audit Criteria

Manitoba Health should have adequate processes in place to ensure the accurate calculation of the client deductible amount in relation to the family unit annual income as reported to Canadian Revenue Agency (CRA). Specifically, we looked to determine whether:

- **Calculation of the deductible amount was in accordance with the *Prescription Drugs Payment of Benefits Regulation* 60/96 -Section 6(1) (Section 5.2.1); and**
- **There was a process to verify the family unit's annual income to information obtained from CRA (Section 5.2.2).**

5.2.1 Deductible Calculation Was In Accordance With Regulation 60/96: Prescription Drugs Payment of Benefits

The deductible calculation methodology is set out in Regulation 60/96: *Prescription Drugs Payment of Benefits* - Section 6(1). The actual calculation of the family deductible was performed within DPIN.

An accurate calculation was dependent on an accurate assessment of total family income. PDP had processes in place to ensure that this income information was obtained prior to any benefits being paid out:

- a download of the relevant data from the CRA (the most common method); or
- by submission of a notice of assessment or other verifiable documentation by the individual themselves.

If a tax return had not been filed, PDP had a process in place to identify the individuals and obtain and confirm the information prior to any claim being processed.

Family circumstances and income may have changed since filing the tax return two years prior. If family income had decreased by greater than 10%, there was a process for the individual to report this change to PDP and have the deductible amount reassessed. In these cases, the family must supply appropriate documentation to back up their request, which was then subject to audit by Manitoba Health.

To assess the adequacy of the process in place, the deductible for two samples of 65 each (clients with changes in the deductible and new clients) was recalculated in accordance with the formula (**Appendix B**) in the regulation. There were no errors in the calculated amounts.

5.2.2 Process In Place To Verify Family Income To CRA Tax Information

PDP had a process in place to verify family income in order to properly calculate the deductible. Verification of income was performed in one of two ways, depending on which option the individual had indicated when they applied for Pharmacare:

- Option A (automatic renewal). Clients indicated they wished to have net income information verified annually to the amounts assessed by CRA. This information was confirmed through a data exchange with CRA. The exchange of information is part of a Memorandum of Understanding between the CRA and Manitoba Health. This memorandum was signed in 2003 and remains in effect with no set termination date.
- Option B (annual self-renewal). Clients submitted either a notice of assessment from CRA, or other verifiable documentation (usually T4s). PDP had an audit process in place in the case of a submission of other documentation.

A sample of the Pharmacare application form can be found in **Appendix C**.

6.0 Manitoba Health's Process For Monitoring Pharmacy Claims

We reached the following overall conclusions on the claims monitoring process audit objective and criteria:

Audit Objective and Criteria	Conclusions
To determine whether the Manitoba Health had adequate processes in place to ensure pharmacy compliance with the applicable sections of *The Prescription Drugs Cost Assistance Act* and *The Pharmaceutical Act*, and their associated regulations; To assess pharmacy compliance with the Act, we focused our review on Manitoba Health's process for monitoring pharmacy claims. In particular, whether:	There was an adequate process in place to ensure that pharmacies were paid the proper amount for the proper cost of the drug claim. There were no processes in place to assess or monitor associated professional fees.
6.1 Accurate reimbursement to the pharmacies Manitoba Health should have processes in place to ensure that pharmacists are accurately reimbursed for the cost of drugs dispensed to persons eligible under the Pharmacare program.	• Manitoba Health had a process in place to ensure accurate reimbursement of drug costs claimed by the pharmacies; and • DPIN was updated on a timely basis to ensure accurate drug pricing.
6.2 Correct payment of Professional fees Manitoba Health should have processes in place to ensure that the professional fees paid are in compliance with the Act and regulations.	• There were no processes in place to assess whether professional fees paid as part of the Pharmacare claim were consistent with the Act and regulations; and • There was no monitoring performed of Pharmacare claims to ensure that professional fees charged were the same for Pharmacare and non-Pharmacare clients.

In reaching the overall conclusions, we examined two key areas that related to Manitoba Health's monitoring of pharmacy claims compliance with the Act:

6.1 Accurate reimbursement to the pharmacies; and

6.2 Correct payment of professional fees.

Detailed audit criteria and observations are presented in the related sections.

6.1 Accurate Reimbursement to the Pharmacies

Audit Criteria

Manitoba Health should have processes in place to ensure that pharmacists are accurately reimbursed for the cost of drugs dispensed to persons eligible under the Pharmacare program. Specifically, we looked to determine whether:

- Manitoba Health had a process in place to substantiate the correct price of a drug paid to the pharmacy based on information provided by the manufacturer/wholesaler and reflected in DPIN as:
  - Maximum allowable price for interchangeable drugs; and
  - Lowest price charged by wholesalers for non interchangeable drugs (**Section 6.1.1**).
- Manitoba Health updated DPIN in a timely manner to reflect the lowest cost of drugs being acquired by the pharmacies (**Section 6.1.2**).

6.1.1 PDP Had A Process To Ensure Correct Drug Pricing

Manitoba Health had defined the correct price of a drug as the manufacturer's suggested price for non-interchangeable drugs and as the lowest priced generic equivalent for interchangeable drugs.

As part of the audit of Pharmacare claims, the price of the drug claimed was compared to the DPIN maximum price allowed. There was no example where a drug price reimbursed by Pharmacare was higher than the amount listed in DPIN. There were examples where the claim price was less than the maximum amount in DPIN.

PDP had undertaken some monitoring of drug prices claimed by pharmacists. PDP analyzed both generic and brand name drugs. This monitoring process was ongoing and no results were available at the time our audit work was completed.

6.1.2 DPIN Was Updated For Price Changes In A Timely Manner

PDP changed drug prices in DPIN upon:

- the initial submission and review of the drug for inclusion in the Formulary; and
- submission and review of updated price to PDP by the manufacturers when a price change occurred.

As was discussed in the OAG Report *Audit of the Pharmacare Program, Manitoba Health* (Pharmacare 1) April 2006, pricing for non-interchangeable drugs eligible

for Pharmacare benefits was kept current by reference to wholesaler's price lists. While price changes could be initiated by PDP, the changes were often initiated by pharmacists via submitted Pharmacare claims that had drug prices different than those in DPIN.

Manitoba Health followed up with the wholesalers to confirm the price before making any changes in DPIN. Pharmacies were kept informed about changes through the Bulletins issued by Manitoba Health. The Bulletins included a list of additions, deletions, and price changes to drugs listed in the Interchangeable Formulary. These were usually updated every three to four months. Bulletins were posted on the Manitoba Health Website and were sent to pharmacies and physicians.

Notification of price changes was usually received well ahead of the effective date of the change. The price that pharmacies charged for claims was capped at the price listed in DPIN.

6.2 Correct Payment of Professional Fees

Audit Criteria

Manitoba Health should have processes in place to ensure that the professional (dispensing) fees paid are in compliance with the Act and Regulations. Specifically, we looked to determine whether:

- **PDP had a process in place to assess whether professional fees billed by pharmacists and paid by Pharmacare were in compliance with the Act and regulations (Section 6.2.1); and**
- **PDP had a process to monitor professional fees to ensure that professional fees charged to Pharmacare were equal to the fees charged to non-Pharmacare covered persons receiving similar prescription drugs and service (Section 6.2.2).**

6.2.1 No Process In Place To Assess Whether Professional Fees Are Compliant With The Act

PDP had no process in place to ensure the amount of professional (dispensing) fees claimed by pharmacists were in compliance with the Act and regulations. Under Regulation 60/96 S.1, the only direction to pharmacists regarding fees charged for a Pharmacare claim was that the individual could be charged:

"a sum not exceeding...

(ii) a professional fee equal to the amount regularly charged by a pharmacist to people who are responsible for paying the fee without reimbursement".

PDP officials indicated that they were aware of the need for a process to assess professional fee compliance. They also indicated that such a process was under consideration as part of the audit procedures that were being developed for pharmacies.

As part of our detailed testing of claims, we audited the professional fees charged and verified that the fee charged complied with the regulation. Although we did not find any discrepancies, the lack of an assessment process increases the potential that Pharmacare clients could be charged a higher fee than non-Pharmacare clients, resulting in the Pharmacare program incurring extra expense.

We recommend that a process be implemented to assess professional fee compliance with the Act.

6.2.2 No Process In Place To Monitor Professional Fees

PDP did not have processes in place to monitor professional fees paid. PDP did not ensure that professional fees charged to Pharmacare were equal to the fees charged to persons responsible for paying the fee without reimbursement.

The PDP Audit and Investigations Officer conducted a sample review of professional fee information contained in DPIN and followed up as part of the development of a pharmacy audit process. He found professional fees in the pharmacies reviewed appeared to be consistent among all pharmacy clients.

Manitoba Pharmaceutical Association (MPhA) officials indicated that their position was that the pharmacist should charge a professional/dispensing fee that was consistent between Pharmacare and non-Pharmacare clients. MPhA indicated that they did not do any work during their field audits of their membership to ensure that this was actually occurring.

We recommend that a process to monitor professional fees be put in place.

7.0 Accuracy And Validity Of Pharmacy Claims

We reached the following overall conclusions on the pharmacy claim accuracy and validity audit objective and criteria:

Audit Objective and Criteria	Conclusions
To determine whether Manitoba Health had adequate processes in place to ensure that only accurate and valid claims are paid. In particular, whether:	Manitoba Health had adequate processes in place to ensure that only accurate and valid claims were paid. The Pharmacare program was not in compliance with the requirements of the Act and regulations in regards to accounting for the recovery of drug costs by Pharmacare beneficiaries from third party insurance providers.
7.1 Manitoba Health processes for pharmacy claims Manitoba Health should have processes in place to identify issues of compliance with key sections of legislation and regulation of the Pharmacare program in relation to payment of claims submitted by pharmacists and clients.	• PDP had adequate processes in place to identify issues of compliance with key sections of the Act and regulations in relation to payment of claims submitted by pharmacists and clients. • PDP had identified relevant sections of the Act and regulations, and had established controls in DPIN to ensure compliance. • Prior to June 2005, there was a lack of effective investigation and audit of the Pharmacare Program. Since that time, an Investigation and Audit officer is in place and an audit program is under development. • There were adequate processes in place to ensure that drug costs covered by other direct government drug benefit programs were excluded from the Pharmacare deductible accumulator. • PDP had inadequate processes in place to account for third party insurance coverage. • There were controls in place to ensure that drugs used in contravention of *The Food and Drug Act, The Narcotics Control Act,* and *The Pharmaceutical Act* were not included in the calculation of the deductible accumulator.

Audit Objective and Criteria	Conclusions
7.2 Selection and audit of pharmacy claims Manitoba Health should have a process in place to review claims paid for audit and carry out audits on a timely basis.	PDP did not have a claims audit process in place at the time of our audit. However PDP was in the process of developing a process to: • Analyze pharmacy claim data; • Prioritize pharmacies for audit; and • Audit claims submitted by the pharmacies. There were adequate processes in place to recover any claims later determined to be invalid.
7.3 DPIN designed to ensure only accurate and valid claims are paid The Drug Program Information Network (DPIN) system should be designed to ensure that only accurate and valid claims are paid by Pharmacare.	DPIN had controls that had been designed into the program to ensure that: • Claims were assessed against key criteria for validity; and • There was a process to assess claims and prevent duplicate billings.

In reaching the overall conclusions, we examined three key areas that relate to Manitoba Health's monitoring of the accuracy and validity of pharmacy claims:

7.1 Manitoba Health processes for pharmacy claims;

7.2 Selection and audit of pharmacy claims; and

7.3 DPIN designed to ensure only accurate and valid claims are paid.

Detailed audit criteria and observations are presented in the related sections.

7.1 Manitoba Health Processes For Pharmacy Claims

Audit Criteria

Manitoba Health should have processes in place to identify issues of compliance with key sections of the Act and regulations in relation to payment of claims submitted by pharmacists and clients. Specifically, we looked to determine whether:

- There was a process for Manitoba Health to identify and investigate issues of compliance with key sections of the Act including:
  - Making false or misleading information;
  - Issuing false prescriptions;
  - False dispensing of drugs;
  - Issuing false receipts for drugs;
  - Proper application of substitution of interchangeable drugs;
  - Accurate application of Parts 1, 2, 3 of the formulary by doctors and pharmacists; and
  - Other applicable legislation, such as *The Narcotic and Controlled Drugs Act* **(Section 7.1.1)**;
- Manitoba Health had a process to account for the cost of drugs recovered by persons from third party insurers when calculating the deductible for Pharmacare, as required by the Act. (Regulation 60/96: Prescription Drugs Payment of Benefits Sec 2(2).) **(Section 7.1.2)**; and
- Manitoba Health ensured that the cost of drugs included in the calculation of the Pharmacare deductible did not include the cost of drugs used in contravention of the following Acts;
  - *The Food and Drug Act* (Canada)
  - *The Narcotics Control Act* (Canada)
  - *The Pharmaceutical Act* **(Section 7.1.3)**.

7.1.1 Sections Of The Act And Regulations Relevant For Compliance Had Been Identified And Monitored.

PDP had adequately identified the relevant sections of the applicable legislation (Acts and regulations) which were the key areas for compliance under the Pharmacare program.

To ensure compliance with these requirements, PDP depended on the input (claims submission by pharmacies) and processing controls within DPIN. DPIN controls also depended on controls included in the Medical Registration system of Manitoba Health, specifically PHINs issued to residents. A valid PHIN was required

for enrollment into the Pharmacare program. DPIN also relied on the accuracy of the information submitted by pharmacists.

Detailed tests of DPIN system controls for claims based on a random sampling of 160 manual claims, 816 oxygen claims, and 1,538 pharmacy claims transactions extracted from DPIN indicated that the system controls were working as designed for each transaction type.

PDP had minimal procedures in place to review and detect instances of non-compliance after a claim had been processed. Prior to June 2005, there was no dedicated audit and investigation function assigned to the Pharmacare program. Audit of Pharmacare compliance prior to June 2005 was the responsibility of the Manitoba Health Internal Investigations Section. PDP officials stated that due to a lack of resources, there was limited audit and investigation work carried out in the Pharmacare program to identify and investigate key areas of compliance in relation to the submission of claims by pharmacies and individuals.

In June 2005, PDP aquired its own dedicated Audit and Investigation Officer. In the period from July 2005 to June 2006 the new PDP Audit and Investigation Officer developed processes and procedures to identify and investigate issues of potential non-compliance with the requirements of Pharmacare.

PDP officials indicated that there has been a need for considerable development time for investigation and audit programs and procedures. As of November 2006, the audit and investigation function within PDP was still in development. The policy and procedures for the Pharmacare audit and investigation function had been drafted and were in review within PDP.

Field visits to pharmacies by the PDP Audit and Investigation Officer had begun, with a total of 30 field visits completed to December 2006. Processes for the review of claims data were being developed.

The PDP Audit and Investigation Officer had begun to carry out reviews of past claims data against eligibility for payment criteria. For example, the PDP Audit and Investigation Officer ran a search for the drug Proscar. The drug is used for the treatment of benign prostate growth (hyperplasia). This treatment is covered by Pharmacare under Part 2 criteria. However, the drug is also used for the treatment of hair loss, a condition which is not covered under Pharmacare. Where claims were identified which did not meet the criteria for coverage under Pharmacare the claims were reversed and the funds recovered. Development and implementation of audit procedures was continuing at the time that our field work was completed.

Due to the small number of pharmacies reviewed up to December 2006 by the PDP Audit and Investigation Officer, there was a potential that there were claims being

processed by the Pharmacare Program for payment to individuals and pharmacies which may not have been in compliance with the requirements of the program.

PDP officials indicated that the audit and investigation function was to continue to expand by obtaining additional staffing.

7.1.2 Inadequate Processes To Account For Third Party Insurance

The Pharmacare program had inadequate processes in place to account for third party insurance payments for drug benefits to people registered for Pharmacare and receiving Pharmacare benefits. Accounting for the reimbursement of drug claims was required in order to ensure the correct calculation of the family unit's deductible under the Act (*The Prescription Drug Cost Assistance Act*) and regulation (*Prescription Drugs Payment Of Benefits Regulation*), Section 2(2) which states:

> *"In determining whether members of a family unit have spent more on the cost of specified drugs than the deductible amount determined under section 6, a person is not considered to have spent an amount on the cost of a specified drug in the following cases:*
>
> *a) the person is entitled to be reimbursed for the cost of the specified drug from a source other than the government, to the extent of the reimbursement.*
>
> *b) the person is entitled to have the cost of the specified drug paid from a fund or pursuant to a program established under a law enacted by Parliament or a Legislature in Canada or elsewhere".*

Application Form

PDP did not have a process by which people could report third party drug insurance coverage for prescription drug costs at the time they applied to the Pharmacare program. Other than the declaration of disclosure on the Pharmacare application form (see **Appendix C**), Pharmacare only required the applicant to provide family unit and income information. Pharmacare did not request third party insurance coverage information. The DPIN system had no means of recording this reimbursement information, even if the person applying to the program did report it.

When applying for Manitoba's Pharmacare program, the applicant must select one of two enrollment options:

- Option A: One Time Program Enrollment; and
- Option B: Annual Application.

If a person applying for Pharmacare chose the One Time Program Enrollment option and had no third party prescription drug insurance, they may not have declared third party insurance at that time. If they subsequently obtained third party insurance, PDP had no process for the person to report this change in coverage. The person would have to cancel their enrollment and then re-apply under the Annual Application option to advise Pharmacare of the change in their third party prescription drug insurance status.

The application form was inadequate for a person who was applying for Pharmacare to report third party prescription drug insurance. As a result, the lack of a process within PDP to address this issue may have resulted in applicants violating the declaration which they were required to sign at the time of application (see **Appendix C**) which states:

> *"I declare that all the information I have provided in this form is complete...I also certify that the prescription drug costs for which I am or will be claiming benefits are not covered by another insurer..."*

PDP had not communicated the requirement for people to report changes in third party insurance to those people enrolling or enrolled in the Pharmacare program. It was unlikely that people would be aware that they should report third party prescription drug coverage. Additionally, PDP had no process to identify cases where an individual's third party prescription drug insurance status had changed.

Accounting for Third Party Insurance

The full cost of prescription drugs purchased by a family unit during the year was accumulated against their deductible amount even if third party insurance benefits had been received. As a result, it was likely that some families obtained Pharmacare benefits before having reached their Pharmacare deductible amount.

As a result, the cost to the Pharmacare program is the cost of the drugs reimbursed to the family unit by third party insurance providers, which are not accounted for (not included in the Pharmacare deductible cost accumulation) as they should be under the requirements of the Act and regulation.

An example of this impact on a family with an income of $55,000 third party insurance coverage of $400 and family drug costs of $3,000 follows. This example illustrates that the family unit drug expenditure paid by Pharmacare would be higher than that allowed in the regulation, because the cost recovered from third party insurance is not being credited towards the accumulator.

Figure 2

	Deductible calculation under Regulation 60/96	Deductible as currently calculated in DPIN
Family drug expenditure	$3,000	$3,000
Less: Cost recovered from third party insurance	400	-
Drug expenditure credited to family unit in the Pharmacare accumulator	2,600	3,000
Pharmacare deductible; calculated as Family Income x Deductible % (e.g., $55,000 x 4%)	2,200	2,200
Family unit drug expenditure paid by Pharmacare	$ 400	$ 800

The total dollar impact on the Pharmacare program as a result of not properly accounting for the recovery of drug costs from third party insurance would be the number of Pharmacare claimants who have third party prescription drug coverage, multiplied by the actual reimbursement received for drug claims not correctly accounted for by the Pharmacare Program.

PDP had not attempted to estimate the dollar impact on the Pharmacare program as a result of the inclusion of third party recoveries of amounts credited against the Pharmacare deductible.

There were no records available in DPIN, or anywhere else in PDP, to identify individuals who had registered for Pharmacare and who also had third party drug benefit plans.

PDP Adjudication of Claims Process

PDP also had inadequate processes in place to ensure that pharmacies adjudicate claims between Pharmacare and third party insurers as required under the Act.

PDP officials were aware that pharmacies had been instructed by third party insurers and pharmacy corporate head offices to adjudicate claims with Pharmacare as the first payer. This was documented by PDP in an internal communication, *Comparison of Private and Public Drug Plan Designs including the Coordination of Benefit Rules*, dated July 31, 2001. Some of the key points from this document included:

- Virtually all third party insurance plans used the public drug programs to minimize their claims liability. The third party insurers required claimants to approach the public plan first. The public plan was therefore considered the "first payer".

- In Manitoba there was legislation in place for coordination of benefits (public plan to be the last payer). The legislation mandated that only "out of pocket expenses" incurred are allocated against the annual claims accumulation amount, but it was not administratively applied, and therefore in practice the province was the first payer.
- Insurance carriers advised pharmacy service providers that the Pharmacare program was considered the first payer and therefore to electronically first submit all prescription claims to the public plan. Some pharmacies were submitting claims pursuant to legislation, while others were submitting prescription claims based on the direction of the insurance carriers.
- The lack of effective benefit coordination provided financial benefits to both the insurance carrier and the individual policy holder, at the cost of the public program. The insurance carrier only provided maximum reimbursement to the policy holder's Pharmacare deductible.

Pharmacare had not attempted to communicate to pharmacies the correct application of the order of adjudication of billing or attempted to identify those pharmacies which were not following the correct application of the regulation.

We recommend that Manitoba Health correct the inconsistency between current practice and current legislation.

7.1.3 Adequate Processes To Exclude The Costs Of "Drugs Used In Contravention Of The Act" From The Pharmacare Deductible Accumulator

Drugs that are used in contravention of the Act cannot be funded through Pharmacare.

As part of our testing of the accuracy and validity of claims, we reviewed the PDP process to ensure that such drugs are excluded from the accumulator. We did not audit any associated procedures around the legal or other actions that might be required in such situations.

"Use in contravention of the Act" has been defined as follows:

Food and Drug Act

- Sale or manufacture of a drug manufactured, prepared, preserved, packaged or stored under unsanitary conditions (8[a]), (11);
- Sale of a drug which has been adulterated (8[b]);
- Sale of a drug that is labeled, packaged processed, sold or advertised in a manner that is misleading or deceptive, or may create an erroneous

impression regarding its character, value, quantity, composition, merit or safety (9[1]);

- Sale of a substance which is labeled, packaged or advertised in such a manner that it can be mistaken for a drug, unless it complies with the standards set for that drug (10[1-3]);
- Sale of any drug described in Schedule F.

Controlled Drugs and Substances Act

- Except as authorized under the regulations, no person shall possess a substance included in Schedule I, II, or III (4[1]);
- No person shall seek or obtain a substance, or the authorization to obtain a substance included in Schedule I, II, III, or IV, from a practitioner unless the person discloses to the practitioner particulars relating to the acquisition by the person of every substance in those Schedules, and of every authorization to obtain such substances, from any other practitioner within the preceding thirty days (4[2]);
- No person shall traffic in, or possess for the purposes of trafficking, a substance included in Schedule I, II, III, or IV or in any substance represented or held out by that person to be such a substance (5).

Pharmaceutical Act

No misrepresentation of drugs

- 63(1) No person shall knowingly sell a drug under the representation or pretense that it is a particular drug that it is not, or contains a substance that it does not.
- Sales on prescription.
- 63(2) No pharmacist shall sell a drug that is specified in a regulation made under clause 74(b) except to a medical practitioner, dentist or veterinary surgeon or pursuant to a prescription of a medical practitioner, dentist or veterinary surgeon.

The *Pharmaceutical Regulation* (Regulation 56/92) also set out the practice standards related to purchasing and dispensing of drugs, which included restrictions on the sale of certain pharmaceuticals outlined in the Manual for Canada's National Drug Scheduling System. (Regulation 56/92, S. 26.1[1]) to 26.1[4])

PDP indicated that the DPIN claims process was that for any claim processed, the drug must be included in the Formulary or required a certification that it meets EDS status. We tested the controls in DPIN that ensure:

- valid prescriber;
- valid pharmacist; and
- valid prescription.

Additionally, the pharmacist must also abide by a professional code of conduct as set out by *The Pharmaceutical Act*.

PDP management indicated that no statistical data had been kept and they did not recall any occurrences of drugs claimed and later found to have been used in contravention of the Act within the last two years.

Section 13 of *The Prescription Drug Cost Assistance Act* allowed for:

- the recovery of benefits paid in error;
- as a result of false or inaccurate information; or
- due to disentitlement for receipt of benefits, by way of court action or withholding of future benefit payments.

PDP management stated that although Section 13 of the Act allows for recovery, the only method for recovering costs for claims later determined to be in contravention of the Acts was withholding future payment. PDP officials suggested that due to the Acts and regulations under which the Pharmacare Program operated, there was a lack of legal recovery procedures for claims later determined to be in contravention of Provincial and federal legislation.

Although PDP officials advised that the potential risk of non-recovery of these costs was low, a review of the governing legislation, regulations and/or policies of the program and any amendments necessary, would allow PDP to pursue recovery of amounts paid for claims later found to be in contravention of *The Food and Drug Act, Controlled Drugs and Substances Act*, or *The Pharmaceutical Act*.

7.2 Selection and Audit of Pharmacy Claims

Audit Criteria

Manitoba Health should have a process in place to review claims paid for audit and carry out audits on a timely basis. Specifically, we looked to determine whether:

- Manitoba Health had a process to analyze claims data in order to identify areas of risk for those Pharmacare claims which have been submitted (**Section 7.2.1**);
- Manitoba Health had a process to prioritize pharmacies for audit (**Section 7.2.2**);
- Manitoba Health carried out audits of claims submitted for accuracy and validity and of submitting pharmacies for compliance with the applicable sections of the Acts and Regulations (**Section 7.2.3**); and
- Manitoba Health should have a process to ensure the recovery of amounts paid out for claims that are later ruled to be invalid (**Section 7.2.4**).

7.2.1 Inadequate Process To Analyze Pharmacare Claims Data

At the time of our review, PDP did not have a claims review process. However, PDP was in the process of developing a process to analyze claims data in order to identify areas of risk for those Pharmacare claims which have been submitted.

In the past, PDP depended entirely on the controls in DPIN for the processing of Pharmacare claims. Claims which failed processing were dealt with on an exception basis, where PDP staff followed up on the claim and obtained or corrected the required information to process the claim.

As mentioned in **Section 7.1.1**, PDP obtained a dedicated Audit and Investigations Officer in June 2005. As of December 2006, he was in the process of developing audit methodology for analysis of DPIN data in order to identify areas of risk. Initial audits of pharmacies and reviews of past claims data had been undertaken. Work was underway to develop processes for analyzing claims data to identify areas of risk and to analyze claims data.

We recommend that Manitoba Health complete the process to analyze claims for audit.

7.2.2 Inadequate Process To Prioritize Pharmacies For Audit

At the time of our review, PDP did not have a pharmacy review process. However, PDP was in the process of developing an adequate process to prioritize pharmacies for audit.

There was no routine audit of pharmacies or pharmacare claims carried out by Manitoba Health. The last involvement of the Department of Health and Healthy Living investigation unit was in 2000 due to the reporting by a third party of fraudulent claims being submitted by a pharmacist.

As at December 2006, the PDP Audit and Investigations Officer was in the process of developing the audit methodology for prioritizing pharmacies for audits based on an analysis of DPIN data. While work was underway to develop these processes, the PDP Audit and Investigations Officer randomly selected pharmacies, with some analysis of DPIN data, for field review.

We recommend that Manitoba Health complete the process of prioritizing pharmacies for audit.

7.2.3 No Audit Of Claims Submitted By Pharmacies

PDP did not carry out audits of claims submitted by individuals or pharmacies for accuracy, validity and compliance with the applicable sections of the Acts and regulations.

As of December 2006 the PDP Audit and Investigations Officer was developing audit strategies for the program but was not carrying out audits of claims.

We recommend that Manitoba Health develop an audit process to review the accuracy and validity of claims submitted by pharmacies.

7.2.4 Adequate Process To Recover Invalid Claims

PDP had a process to ensure the recovery of claim amounts paid out that were later determined to be invalid.

PDP depended on control processes in DPIN to detect instances of invalid claims submitted by pharmacies.

Our review of DPIN claims controls and field testing of the sample of 1,538 transactions to pharmacy records found no exceptions to this practice.

Examination of sample transactions to pharmacy records revealed that there may have been instances where a prescription technically should have been ruled to be "invalid" but PDP would not be able to detect this because it is only apparent when reviewing the original prescription which is on file in the pharmacy records. PDP does not have direct access to these prescription records.

An example of such situations would be:

- Where "meets EDS" (meets the Exception Drug Status criteria) was not noted on the original prescription by the prescribing doctor or the dispensing pharmacist for a prescription where a Part 2 drug was dispensed, as required for the claim to be paid by the Pharmacare program.
- Where the claim was filled for a refill where the original prescription was written by the doctor with unlimited refills ("refill prn").

In such cases above, the prescription and the related claim technically could be ruled invalid for payment under the Pharmacare program. However because PDP does not conduct field audits of the original records, the PDP cannot detect such claims.

PDP was considering including sampling of original prescriptions as part of the PDP audit procedures. Where required information was insufficient, the claim would be ruled invalid and the claim paid would be recovered.

7.3 DPIN Designed To Ensure Only Accurate And Valid Claims Are Paid

Audit Criteria

The Drug Program Information Network (DPIN) system should be designed to ensure that only accurate and valid claims are paid by Pharmacare. Specifically, we looked to determine whether:

- **There were controls within DPIN to assess claims for payment against set criteria, and ensure the validity of key payment processing information, such as:**
  - **Legitimate pharmacy;**
  - **Legitimate prescriber;**
  - **Legitimate Manitoba Health Number;**
  - **Approved Pharmacare application;**
  - **Approved Formulary drug; and**
  - **Correct application of Formulary interchangeability of drugs. (Section 7.3.1)**
- **There were controls within DPIN to ensure that claims were assessed to detect instances when claims may be questionable, due to instances such as duplicate billings, reversal of claims, and multiple refills (prescription splitting). (Section 7.3.2)**

7.3.1 DPIN Controls Were Sufficient To Ensure Pharmacy Claims Were Valid

The process for submission and payment of claims through DPIN was based on the requirements of the applicable acts and regulations. DPIN had checks in place to ensure that claims were valid. Claim data was verified in each applicable field against a set of programmed criteria for that field as the claim was being entered by the pharmacy. Any data which fell outside of the criteria was rejected, and the claim could not be filed until it was corrected. Any errors in the claim being submitted by a pharmacy had to be cleared by the pharmacist before processing; otherwise the claim was not submitted to Pharmacare for payment.

PDP verified the validity of prescribers and pharmacies with the respective professional bodies in order to be included in DPIN's database. We tested a sample of prescribers and pharmacists to ensure that only valid individuals were added to DPIN. We noted no instances of individuals added without verification by the professional body. PDP also had a system to remove prescribers and pharmacists who had left the province or were not practicing.

We also audited a sample of claims submitted and paid by Pharmacare. This sample was selected and substantiated to the claims data on file within PDP and Manitoba Health. Additionally, we substantiated the detail of the claims to the original prescriptions on file in the dispensing pharmacies.

We tested a total of 1,538 Pharmacare claims. Of those 1,538 claims, we could not locate 439 original prescriptions, or 28% of the total sample, on file at the pharmacy. These 439 prescriptions were divided into two groups:

Phone in prescriptions	372
No original prescription located on file in the pharmacy	67
Total no original written prescriptions	439

Officials of the Manitoba Pharmaceutical Association (MPhA) advised that a valid prescription was considered to exist when the doctor provided a verbal prescription order to the pharmacist. This was what occurred with phone in orders. A phone in prescription was documented for Pharmacare by the pharmacist's record for that claim.

In order to substantiate the 439 claims where an original written prescription could not be located in the pharmacy, we confirmed a sample of 60 of those Pharmacare claims with the writing physician (20 individual physicians). All were subsequently confirmed by the physician as being a valid prescription.

7.3.2 DPIN Controls Were Sufficient To Detect Questionable Claims

DPIN had controls in place to assess claims and prevent duplicate billings. DPIN maintained a database of current prescriptions that had been filled. All claims were matched against this database to determine if there was a duplicate prescription number, date, or pharmacy number.

For claim reversals, pharmacists had up to 14 days to make a reversal in DPIN. After that, reversals had to be done through a manual application to PDP. This was the responsibility of the dispensing pharmacist. If the pharmacist had been paid, the reversal was withdrawn directly from their account or deducted from their next payment.

There was no process in place to investigate claims ruled as invalid by DPIN, nor were any error reports or exception documents created for rejected or failed claims. All errors had to be corrected by the pharmacy prior to the claim being processed. The pharmacist was required to perform this task if the claim was to be initially processed, therefore there was no need for PDP to investigate invalid, rejected, or failed claims.

8.0 Pharmacy Processes for Compliance

We reached the following overall conclusions in relation to the pharmacy compliance process audit objectives and criteria:

Audit Objective and Criteria	Conclusions
To determine whether the pharmacies are complying with the procedures and guidelines related to making accurate and valid claims. In particular, whether:	All pharmacies used the Drug Program Information Network (DPIN) system. Controls within the DPIN system ensured that claims were accurate.
8.1 Pharmacy processes to ensure compliance	
Pharmacies should have processes in place to ensure they are aware of the requirements of legislation and are in compliance with key sections of legislation and regulations of the Pharmacare program in relation to claims submitted by pharmacists.	The Pharmacies had processes in place to ensure that they were kept current on the requirements of The Prescription Drug Cost Assistance Act and its regulations.

In reaching the overall conclusions, we examined one key area that related to Manitoba Health's monitoring of pharmacy compliance with the Act.

Detailed audit criteria and observations are presented in the related section.

8.1 Pharmacy Processes To Ensure Compliance

Audit Criteria

Pharmacies should have processes in place to ensure they are aware of the requirements of legislation and are in compliance with key sections of legislation and regulations of the Pharmacare program in relation to claims submitted by pharmacists. Specifically, we looked to determine whether:

- **There were processes in place for pharmacies to utilize Manitoba Health distributed DPIN Procedure Manuals and other processes to ensure pharmacists were kept current on the requirements of *The Prescription Drug Cost Assistance Act* and its regulations (Act) (Section 8.1.1).**

8.1.1 Pharmacies Had Processes In Place To Ensure Compliance With The Act

Pharmacies had processes in place to ensure that they were up to date with the Act and regulations. However, policy and procedures manuals kept by the pharmacies were focused on internal pharmacy operations rather than with compliance with the Act. Issues such as claims adjudication between Pharmacare and third party insurers were not addressed in the pharmacy manuals.

While many of the pharmacies retained the DPIN manual originally issued in 1995, there was evidence that most had not been utilized in some time. In some of the newer pharmacies, the pharmacist indicated that they had not received a physical copy of the DPIN manual. Pharmacists did appear to be aware of the general outline of the Act and regulations, although pharmacists indicated that there were Pharmacare program details which were not well understood, or required them to seek clarification from PDP.

PDP management had identified particular information required to ensure compliance with the Act when a claim is filed by the pharmacists. This information had been incorporated in DPIN and must be correctly entered by the pharmacist or the claim would be rejected. PDP management identified the sources for ensuring compliance as being drawn from sections of the following:

- *The Pharmaceutical Act*;
- Regulation 60/96; and
- the DPIN Pharmacy Manual.

The majority of pharmacists indicated that they relied upon DPIN to ensure that the claim was processed correctly. The fact that the pharmacy DPIN manuals were

not up-to-date should have had no effect on ensuring claim compliance, as DPIN performed that function.

PDP also distributed Bulletins to the pharmacies to provide updates of any changes in the Act, regulations, or Formulary. Prior to the effective date of any regulatory change, PDP staff was prepared to answer pharmacists' questions about the changes. A question and answer document outlining the change was also sent to pharmacists ahead of the effective date of the change. The majority of the 35 pharmacy managers interviewed indicated that they recalled seeing the bulletins regarding changes in the Formulary pricing.

There is a potential risk that pharmacists may not have a correct understanding of the program requirements by relying on DPIN control systems. To ensure that pharmacists' fully understand the Pharmacare program requirements, it would be beneficial for PDP to review the DPIN manual and update it to ensure that it reflects current practice.

9.0 Summary of Recommendations

PROGRAM ELIGIBILITY

Communication

- That there should be a documented communication strategy. **(Section 4.1.1)**
- That the communication strategy appropriately address the needs of all client groups. **(Section 4.1.2)**

Program Monitoring

- That a monitoring process be implemented to detect individuals who acquire third party insurance coverage. **(Section 4.3.1)**
- That a process be implemented for reporting and updating third party insurance coverage. **(Section 4.3.2)**

Policy and Procedures Manuals

- That manuals be standardized to ensure the consistency and inclusion of all necessary information. **(Section 4.4.1)**
- A formal process be implemented to ensure policy and procedures are updated on a regular basis. **(Section 4.4.2)**

PROCESS FOR MONITORING PHARMACY CLAIMS

Professional/Dispensing Fees

- That a process be implemented to assess professional fee compliance with the Act. **(Section 6.2.1)**
- That a process to monitor professional fees be put in place. **(Section 6.2.2)**

ACCURACY AND VALIDITY OF PHARMACY CLAIMS

Third Party Insurers

- That Manitoba Health correct the inconsistency between current practice and current legislation. **(Section 7.1.2)**

PDP Audit Function

- That Manitoba Health complete the process to analyze claims for audit **(Section 7.2.1)**
- That Manitoba Health complete the process of prioritizing pharmacies for audit. **(Section 7.2.2)**
- That Manitoba Health develop an audit process to review the accuracy and validity of claims submitted by pharmacies. **(Section 7.2.3)**

10.0 Departmental Response

Drug therapy is an important part of an integrated health care system in Canada. Appropriate drug therapy has the potential to improve health outcomes and reduce costs in other aspects of the health system such as acute care and long term care. While provincial drug programs across the country have been experiencing rapidly increasing costs, according to the Canadian Institute for Health Information, Manitoba continues to provide the highest coverage in Canada, paying 53% of prescription expenditures.

Manitoba Pharmacare is a universal drug benefit program established to protect all eligible residents from financial hardship resulting from expenses for prescription drugs. As Pharmacare is a publicly funded program, Manitoba Health and Healthy Living (MHHL) has a duty to ensure that all funds are spent appropriately and continues to

implement changes designed to improve program access to Manitobans.

Since the Office of the Auditor General (OAG) Report on the Pharmacare program in 2006, MHHL has completed the restructuring process to establish three functional units – Operations Management, Professional Services, and Drug Management Policy to facilitate comprehensive, coordinated and proactive drug benefit program management for publicly funded drug programs in Manitoba.

As a first step, in the fall of 2005, MHHL established a Drug Management Policy Unit to provide focused policy capacity and to develop and implement a strategic policy framework.

In reference to the recommendations made in the OAG's 2006 report on Pharmacare to manage promotion and appropriate prescribing, measure health outcomes and facilitate the utilization of the most cost-effective products, MHHL has shifted its focus from supply-side initiatives to demand-side initiatives. Notable achievements are outlined below:

- *In 2007, MHHL introduced Utilization Management Agreements (UMAs) as a key component to managing Pharmacare expenditures. UMAs are now a standard part of the drug submission and decision-making framework for all new products. The manufacture's submission must include a statement of the incremental value or health outcome that the product offers over its competitors. In arriving at the UMA, the price of the product may be negotiated in addition to the manner in which the province will be reimbursed if government's actual expenditures exceed those estimated by the manufacturer. Manufacturers are also required to describe how they plan to ensure appropriate utilization and how health outcomes will be measured.*
- *In February 2007, MHHL launched the Deductible Installment Payment Program for Pharmacare (DIPPP). DIPPP assists eligible individuals and families who*

experience cash flow challenges with high drug costs relative to their income, by allowing them to pay their deductible in monthly installments through their Manitoba Hydro energy account.

- *In November 2007, MHHL also introduced new generic product submission requirements to obtain more equitable generic drug prices for Manitobans and ensure adequate supply for pharmacists.*

These actions, which take into account the OAG's 2006 recommendations, demonstrate MHHL's commitment to implementing evidence-based policies and procedures that provide the underpinning for a sustainable, cost-efficient and effective Pharmacare program.

It is noted that the recommendations outlined in the follow-up report, Pharmacare Program – Part 2, suggest enhancement in the following key areas: communication, audit functionality; and internal work process improvements. To that end, the Department can advise that work has been initiated to address these recommendations. Specifically:

- *MHHL is developing a comprehensive and cost-effective communication strategy to inform key stakeholders of updated information including program benefits, formulary updates, and new initiatives such as the focus on utilization management. An assessment of current communications initiatives is underway to assist in identifying gaps. The communication strategy is expected to include regularly-scheduled communications to health professionals, patients, and pharmacy service providers.*
- *The audit and investigations function, which was previously aligned with the Operational Program Management Unit, was transitioned to the Drug Management Policy Unit in order to create a broader, more proactive and process-focused strategic focus. As part of ongoing efforts to increase the effectiveness of Provincial Drug Programs, the mandate and scope of the audit and investigations function is currently under review with the goal to create a quality assurance/*

risk management focus. The role of the recently created Audit and Investigation Officer would be a component of this function and would be redeveloped as appropriate. A business plan is currently being developed which will outline the revised scope, mandate and resource requirements to effectively and efficiently address risk priorities associated with Pharmacare.

- *MHHL has initiated discussions with the Manitoba Society of Pharmacists (MSP), the professional body representing the majority of pharmacy service providers in Manitoba, on the development of an agreement that would clarify policies and improve communications. This agreement would serve to improve accountability and clearly outline the relationship between the department and individual community pharmacy providers.*
- *MHHL is evaluating the current practices of the Pharmacare program and the current regulations regarding third party insurance coverage and will ensure their consistency.*
- *MHHL is reviewing the work processes of the program to ensure that Pharmacare continues to be patient-focused, cost effective and efficient.*

MHHL is committed to evidence-based and cost-effective policy development in combination with continues learning and the adoption of best practices to ensure cost-effective and efficient service delivery to support the long-term sustainability of the Pharmacare program.